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MARCH 27, 2007

PROJECT UPDATES FOR MARCH

MICHIGAN'S LTC CONNECTIONS LOGIC MODEL

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LIST OF WEB SITES FOR BACKGROUND MATERIAL FOR THE SYSTEMS TRANSFORMATION GRANT

PERSON-CENTERED PLANNING GUIDELINES - DRAFT

CONSUMER TASK FORCE

UPDATE OF PROJECTS

MARCH 007

Self- Determination in Long Term Care Project
March 2007

As of this writing, March 15, 2007, there are 19 participants enrolled in Self Determination from 11- Burnham Brook, 6 - UPCAP, 2 -Tri-County Office on Aging. They have all contracting with Guardian Trac as fiscal intermediary. Detroit AAA was to have signed with Guardian Trac as well, last week. Two fiscal intermediaries have had readiness reviews conducted. So far, the feedback from participants has been very positive, with reports of feeling "ecstatic".

Policy and practice guidelines for Person Centered Planning have been distributed as a draft for feedback, which is slowly coming back to Rob to coordinate.

Our next big push is to train the waiver sites on the MI Choice waiver and amendments. We have 8 regional trainings scheduled, beginning March 15.

After that, we will begin training the rest of the wavier sites, who were not Pioneers on Person Centered Planning and Self Determination. We will conduct two sessions in three regions over the summer. This should prepare the sites for enrollment in October.

I am still finishing an operations manual, and the quality measuring tools.

We are also coordinating our work with the goals stated in the System Transformation grant regarding increased choice and control for participants in the long term care system, specifically focusing on person centered planning, participant directed

services and individual budgets. This will include policies and practices along with training and information.

We have begun work on renewing the MI Choice waiver. It is up for renewal in June.

For more information contact me at 517.335.5671
munizt@michigan.gov

Independence Plus and Money Follows the Person Grants

March, 2007

MI Choice version of the PCP in LTC Policy and Practice Guideline

Thanks to those of you who were involved with the PCP Action League for your valuable input on the draft PCP in LTC document. The next round of revisions to the document have been completed. Next, this document will be sent out for comment from program, advocates and departmental readers and interested parties. The scope of the document is for PCP in MI Choice Self-Determination Programs at this time Copies for CTF members were distributed.

Self-Determination Training and Conference Planning

- The 2007 June Self-Determination Conference will be on June 11 & 12 at the Lansing Holiday Inn South. If you have a suggestion for a presentation for this event, please contact Rob Curtner at 517 335-8710. At this time some of the keynote speakers have been contracted and a committee is working to identify the breakout speakers. Again this year, consumers are invited to sell goods and services from micro-enterprises.
- Additional training for Working with Fiscal Intermediaries, Consumers as Employers, and other topics is being planned at this time.
- The curriculum materials for the Paraprofessional Healthcare Institute course on "**Employing, Supporting and Retaining Your Personal Assistant"** can be found at this web address. http://198.109.129.5:3455/sdl/74

1915bc Waiver Development

- An internal draft of a concept paper describing the scope, purpose and methods for a cost neutral Medicaid benefit in one or two counties in support of community living options for elders and persons with disabilities is being developed.
- Agreement on the content of this paper between OLTCSS and the MSA is nearly complete.
- The next steps towards a waiver request on this are to discuss the Concept Paper with CMS and to complete a feasibility study.
- The waiver request is scheduled to be completed by October 1, 2007.

The 2007 CMS Conference was held from March 5-7. The materials from presentations for this event have not been posted on the web as yet. Call Rob Curtner for specific requests to be emailed to you.

Long-Term Care Supports and Services Advisory Commission
March 2007

Commission Membership:

Robert Allison was appointed to represent direct care staff providing long term care supports and services for a term expiring December 31, 2010.

RoAnne Chaney was reappointed to represent primary or secondary consumers of long-term care supports and services for a term expiring December 31, 2010.

Marsha Moers was reappointed to represent primary or secondary consumers of long-term care supports and services for a term expiring December 31, 2010.

Jon Reardon was reappointed to represent providers of Medicaid-funded long term care supports and services for a term expiring December 31, 2010.

As a result of a resignation, one vacancy exists for a primary or secondary consumer of long term care supports and services for a term expiring December 31, 2009.

Update:

The February Advisory Commission meeting was cancelled. In its place a 2-day retreat was held to plan and prioritize Commission work for the upcoming year. Leadership responsibilities were transitioned to a new chair, Andrew Farmer. Executive Committee members include the Commission Chair, Hollis Turnham, Vice Chair, RoAnne Chaney, Secretary, Christine Chesny and Jon Reardon.

The 2-day agenda focused on building a broader understanding among Commission members of the task force recommendations, issues orientation, establishing priorities and developing a work plan for the conduct of Commission business in 2007, and building a strong relationship with the Office of LTC Supports and Services.

The Advisory Commission meets on March 26th and will review draft operational guidelines covering a host of responsibilities and tasks that were developed as an outcome of the retreat. The draft guidelines are intended to improve and speed the functioning of the Commission in planning and setting agendas, managing their meetings, responding to public comment, setting and maintaining short term public policy priorities, and SPE evaluation and monitoring.

The next meeting will be held at 1:00 p.m. on April 23, 2007 in the MDCH Conference Center, 1st Floor, Capitol View Building, 201 Townsend St., Lansing.

Deficit Reduction Act/Money Follows the Person
March 2007

The first task is to develop an Operational Protocol. An internal group met last week for a preliminary sorting of what needs to be done. A stakeholder group will be assembled later this month. In addition, a separate group is working on the reporting requirements, which are extensive. CMS is bringing the Department of Housing and Urban Development into the discussion, beginning with a grantee teleconference on 3/28 that will provide technical assistance on addressing the housing barriers to nursing facility transitions.

	COUNTY	Registry Management Associate	Date of Brochure Mailing	Date of DHS Meeting	# Responding to Brochure	Date of Upcoming Orientations	# of RSVPs for Upcoming Orientation	# of Orientations Held	Total # of Providers at Orientation	# of Approved Providers	# of Providers Approval Pending	# Pending for referrals more than 2 mths	# of Providers Denied	# of Orientation Walk outs	# of Consumers	# of Referrals made	# of referral letters sent or calls made	# Inactive due to enough work	# Inactive does not wish to be on registry	# Inactive other	Removed from registry	
1	**ALCONA**	CJ	05/12/06	09/19/06	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	
2	**ALGER**	Brandy	08/15/06	08/15/06	1			1	1	0	0	0	0	0	0	0	0	0	0	0	0	*Provider wishes to work in Marquette ONLY*
3	**ALLEGAN**	Brandy	07/21/06	08/02/06	13			2	6	4	0	1	0	0	1	4	2	1	0	0	0	*New provider responses - never done HH before*
4	**ALPENA**	CJ	05/12/06	07/11/06	5			1	2	2	0	0	0	0	1	1	1	0	0	0	0	*The Provider that attended was from Montmorency County.*
5	**ANTRIM**	CJ	05/12/06	04/20/06	1			2	2	2	0	0	0	0	1	1	1	0	0	0	0	
6	**ARENAC**	Sarah	02/06/06	03/06/06	25			1	7	3	0	0	0	0	1	3	1	1	0	1	3	
7	**BARAGA**	Brandy	06/28/06	07/13/06	3			1	0	0	0	0	0	0	0	0	0	0	0	0	0	*Provider didn't show*
8	**BARRY**	CJ	02/13/06	01/26/06	9			1	2	2	0	0	0	0	0	0	0	0	0	0	0	
9	**BAY**	Sarah	02/06/06	03/06/06	104			5	39	23	3	0	1	4	34	258	54	2	1	0	5	
10	**BENZIE**	CJ	05/12/06	04/05/06	4			1	2	2	0	0	0	0	0	0	0	0	0	0	0	
11	**BERRIEN**	Brandy	06/28/06	07/18/06	45			2	7	3	0	0	1	0	0	0	0	0	0	3	0	
12	**BRANCH**	Brandy	08/25/06	09/14/06	10			1	2	2	0	0	0	0	0	0	0	0	0	0	0	
13	**CALHOUN**	Brandy	06/28/06	06/08/06	26			1	3	2	0	1	0	0	0	0	0	0	0	0	0	
14	**CASS**	Brandy	06/28/06	07/27/06	7			1	2	0	0	0	0	0	0	0	0	0	0	1	0	*1 Provider has not phone no. - inactive*
15	**CHARLEVOIX**	CJ	05/12/06	04/25/06	1			1	1	2	0	0	0	0	0	0	0	0	0	0	0	
16	**CHEBOYGAN**	CJ	06/28/06	05/02/06	3			1	1	0	0	0	0	0	0	0	0	0	0	0	0	
17	**CHIPPEWA**	Brandy	06/28/06	07/11/06	4			1	1	1	0	0	0	0	0	0	0	0	0	0	0	
18	**CLARE**	CJ	03/06/06	04/06/06	14			1	3	6	0	0	0	0	2	10	2	0	0	0	0	
19	**CLINTON**	CJ	07/01/05	09/20/05	12			2	7	2	0	1	0	0	1	5	1	0	2	0	1	
20	**CRAWFORD**	CJ	05/09/06	04/26/06	6			1	2	2	0	0	0	0	2	4	2	0	0	0	0	
21	**DELTA**	Brandy	06/28/06	07/12/06	9			1	4	1	0	1	0	0	0	0	0	1	0	0	0	
22	**DICKINSON**	Brandy	06/28/06	07/13/06	7			1	3	1	0	0	0	0	0	0	0	0	0	2	0	

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23	**EATON**	CJ	07/01/05	02/15/06	18			5	4	4	1	0	0	0	5	17	5	0	2	0	0	
24	**EMMET**	CJ	06/28/06	04/25/06	5			1	2	3	1	0	0	0	0	0	0	0	0	0	0	*waiting for MI DL/ID*
25	**GENESEE**	Sarah	07/01/05	11/29/05	293			10	78	40	16	0	2	3	51	433	83	2	0	6	13	
26	**GLADWIN**	CJ	03/06/06	04/06/06	13			1	6	5	0	0	0	0	1	5	2	0	0	0	1	*moved*
27	**GOGEBIC**	Brandy	07/21/06	08/16/06	4			1	3	1	0	0	0	0	0	0	0	1	0	1	0	
28	**GRAND TRAVERSE**	CJ	05/12/06	05/25/06	11			1	6	5	0	1	2	0	0	0	0	0	0	0	0	
29	**GRATIOT**	CJ	02/13/06	09/20/06	4			1	1	0	0	0	0	0	0	0	0	0	0	0	0	*Provider not from Gratiot*
30	**HILLSDALE**	Tanya	05/12/06	06/27/06	7			2	2	2	0	1	0	0	0	0	0	0	0	0	0	
31	**HOUGHTON**	Brandy	06/28/06	07/13/06	7			1	0	0	0	0	0	0	0	0	0	0	0	0	0	
32	**HURON**	Sarah	03/06/06	05/30/06	6			1	1	1	0	0	1	0	1	1	1	0	0	0	0	
33	**INGHAM**	CJ	07/01/05	08/01/05	112			16	61	40	1	2	2	3	81	673	159	7	2	1	3	*Includes Tri. and Shiawassee and Livingston*
34	**IONIA**	CJ	02/13/06	02/07/06	26			2	5	4	0	0	0	0	8	22	8	0	0	0	0	
35	**IOSCO**	CJ	05/12/06	09/12/06	3			1	2	2	0	0	0	0	0	0	0	0	0	0	0	
36	**IRON**	Brandy	07/21/06	07/13/06	6			1	1	1	0	0	0	0	0	0	0	0	0	0	0	
37	**ISABELLA**	Sarah	04/06/06	05/08/06	9			1	1	2	0	0	0	0	2	11	3	0	0	0	1	
38	**JACKSON**	Leesa	04/14/06	04/19/06	24			3	10	3	0	0	7	0	1	3	1	0	0	0	0	
39	**KALAMAZOO**	Brandy	05/12/06	05/16/06	37	03/29/07		2	24	7	0	3	3	5	2	7	2	0	0	8	0	*1 Provider denied due to no ID. Wants to attend next I.S.*
40	**KALKASKA**	CJ	05/12/06	04/20/06	2			1	1	0	0	0	0	0	1	0	0	0	0	0	0	*Tried 2x to meet with provider for intro session*
41	**KENT**	Ian	06/28/06	06/14/06	172			4	42	36	5	5	1	2	16	138	29	1	0	1	0	
42	**KEWEENAW**	Brandy	06/28/06	07/13/06	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	
43	**LAKE**	CJ	04/03/06	07/27/06	2			1	2	1	0	0	1	0	2	6	3	0	0	0	0	
44	**LAPEER**	Sarah	06/28/06	07/27/06	16			1	7	3	0	0	0	0	1	5	1	1	0	0	2	

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45	**LEELANAU**	CJ	05/12/06	05/25/06	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	
46	**LENAWEE**	Leesa	05/12/06	06/13/06	14			1	2	1	0	0	0	1	1	2	1	0	0	0	0	
47	**LIVINGSTON**	CJ	07/01/05	01/30/06	6			1	1	1	0	0	0	0	2	10	3	0	0	0	0	*with Ingham.*
48	**LUCE**	Brandy	06/28/06	07/12/06	2			1	1	1	0	0	0	0	1	1	0	0	0	0	0	*Provider did not work out.*
49	**MACKINAC**	Brandy	05/12/06	05/02/06	2			1	0	0	0	0	0	0	2	0	0	0	0	0	0	*told me she was referred by Kim Stardevant*
50	**MACOMB**	Sarah	3/06/06	09/20/05	124			6	56	14	13	0	0	6	53	463	97	2	1	5	6	
51	**MANISTEE**	CJ	05/04/06	04/05/06	7			1	1	0	0	0	0	1	0	0	0	0	0	0	0	*Provider never returned application*
52	**MARQUETTE**	Brandy	07/21/06	08/15/06	13			1	3	4	0	0	0	0	0	0	0	0	0	0	0	
53	**MASON**	Brandy	07/21/06	08/02/06	4			1	2	2	0	0	0	0	0	0	0	0	0	0	0	
54	**MECOSTA**	Brandy	05/12/06	04/18/06	11			1	5	2	0	0	1	0	0	0	0	0	0	2	0	
55	**MENOMINEE**	Brandy	06/28/06	07/12/06	11			1	8	3	0	0	0	0	1	2	1	0	0	5	0	
56	**MIDLAND**	Sarah	02/06/06	03/08/06	14			1	5	1	0	0	0	0	1	5	2	0	0	0	0	
57	**MISSAUKEE**	CJ	05/12/06	04/05/06	7			1	4	6	0	0	0	0	1	5	2	0	0	0	0	
58	**MONROE**	Leesa	05/12/06	06/22/06	8			1	2	1	0	0	1	0	0	0	0	0	0	0	0	
59	**MONTCALM**	Brandy	05/12/06	02/07/06	30	02/23/07	5	3	17	6	0	0	0	0	4	17	4	1	0	3	0	
60	**MONTMORENCY**	CJ	06/28/06	08/24/06	3			1	1	1	0	0	0	0	0	0	0	0	0	0	0	*Provider didn't show*
61	**MUSKEGON**	Brandy	05/12/06	05/04/06	52			2	13	8	0	0	2	0	1	5	1	0	0	2	0	*one provider from Ottawa*
62	**NEWAYGO**	Brandy	08/15/06	07/27/06	14	02/20/07	4	2	6	1	0	0	0	0	4	7	3	0	0	0	0	
63	**OAKLAND**	CJ	07/01/05	& 1/5/06	238			14	71	45	4	0	5	5	77	496	127	2	1	3	11	*Pendings: 3-Ref and 1-waiting for MI DL*
64	**OCEANA**	Brandy	07/21/06	08/02/06	14			1	5	4	0	0	0	0	0	0	0	1	0	0	0	
65	**OGEMAW**	CJ	05/12/06	05/10/06	9			1	4	3	0	0	0	0	0	0	0	0	0	0	0	
66	**ONTONAGON**	Brandy	07/21/06	08/16/06	7			1	5	3	0	0	1	1	1	2	1	0	0	0	0	

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67	**OSCEOLA**	CJ	03/06/06	04/18/06	10			1	3	2	0	0	0	0	0	0	0	0	0	1	0	
68	**OSCODA**	CJ	06/28/06	08/24/06	3			1	1	1	0	0	0	0	1	1	1	0	0	0	0	
69	**OTSEGO**	CJ	05/29/06	09/19/06	12			1	10	7	1	0	0	0	7	35	8	0	0	1	0	
70	**OTTAWA**	Brandy	05/12/06	05/24/06	12	03/21/07		1	6	4	0	0	1	1	1	2	1	1	0	0	0	
71	**PRESQUE ISLE**	CJ	06/28/06	07/11/06	2			1	1	0	0	0	0	0	0	0	0	0	0	1	0	
72	**ROSCOMMON**	CJ	05/12/06	05/23/06	8			1	3	1	0	0	0	0	1	3	1	0	0	0	0	
73	**SAGINAW**	Sarah	02/06/06	[illegible] & 1/5/06	221			4	69	37	22	0	3	1	33	253	47	0	0	1	12	
74	**ST. CLAIR**	Sarah	06/28/06	07/27/06	42			2	11	7	0	1	0	0	4	34	7	0	0	1	1	
75	**ST. JOSEPH**	Brandy	06/28/06	06/20/06	4			1	3	0	0	0	0	2	0	0	0	0	0	1	0	
76	**SANILAC**	Sarah	03/06/06	06/07/06	10			2	4	3	0	0	0	0	0	0	0	0	0	1	0	
77	**SCHOOLCRAFT**	Brandy	08/15/06	08/15/06	3			1	1	0	0	0	0	0	0	0	0	0	0	0	0	*Provider decided the registry wasn't for him*
78	**SHIAWASSEE**	CJ	01/30/06	01/30/06	25			4	20	6	0	0	0	1	0	0	0	1	0	0	1	*with Ingham.*
79	**TUSCOLA**	Sarah	03/06/06	06/07/06	10			1	9	3	0	0	0	0	1	6	2	0	0	0	0	
80	**VAN BUREN**	Brandy	06/28/06	06/20/06	29	03/06/07		1	4	1	0	0	1	2	6	23	9	0	0	0	0	*Left message 11/29 to schedule I.S.*
81	**WASHTENAW**	Leesa	07/01/05	09/21/06	70			5	33	16	3	0	2	1	10	53	13	1	0	1	0	
82	**WAYNE**	Leesa	11/12/06	09/12/06	1633	03/15/07	18	14	201	146	40	23	8	4	14	94	19	0	1	2	0	
83	**WEXFORD**	CJ	05/12/06	04/05/06	18			1	7	5	0	0	0	0	2	7	2	0	0	0	0	
	TOTALS				**3788**	**6**	**27**	**171**	**954**	**566**	**110**	**40**	**46**	**44**	**443**	**3133**	**713**	**26**	**10**	**54**	**60**	
	Change from January report				+185			+12	+141	+78	+20	+13	+2	+5	+45	+374	+81	0	+1	0	+9	

68 Counties have approved providers living in their county

15 Counties without approved providers. Only 5 of these counties have no providers who are willing to go there: Alger, Baraga, Keweenaw, Leelanau, Schoolcraft.

Medicaid Infrastructure Grant (MIG) Update:
March 2007

There are presently 949 Freedom to Work (FTW) participants. This is up from 928 last month.

The MIG continues to work with MSA to address the other issues shown on the issues grid sheet. Theresa continues to track and research these challenges and draft related policies/procedures to address the issues.

Jackie Doig met with MSA and MIG on March 14 questioning if a married person (with unearned income over 100% of the FPL) presently Medicaid eligible under AD Care as a family of two (2) would be eligible for FTW. Paul Reinhart was in attendance and after hearing discussion showed support for this and directed MSA staff to provide details on how this would work. We will update in April.

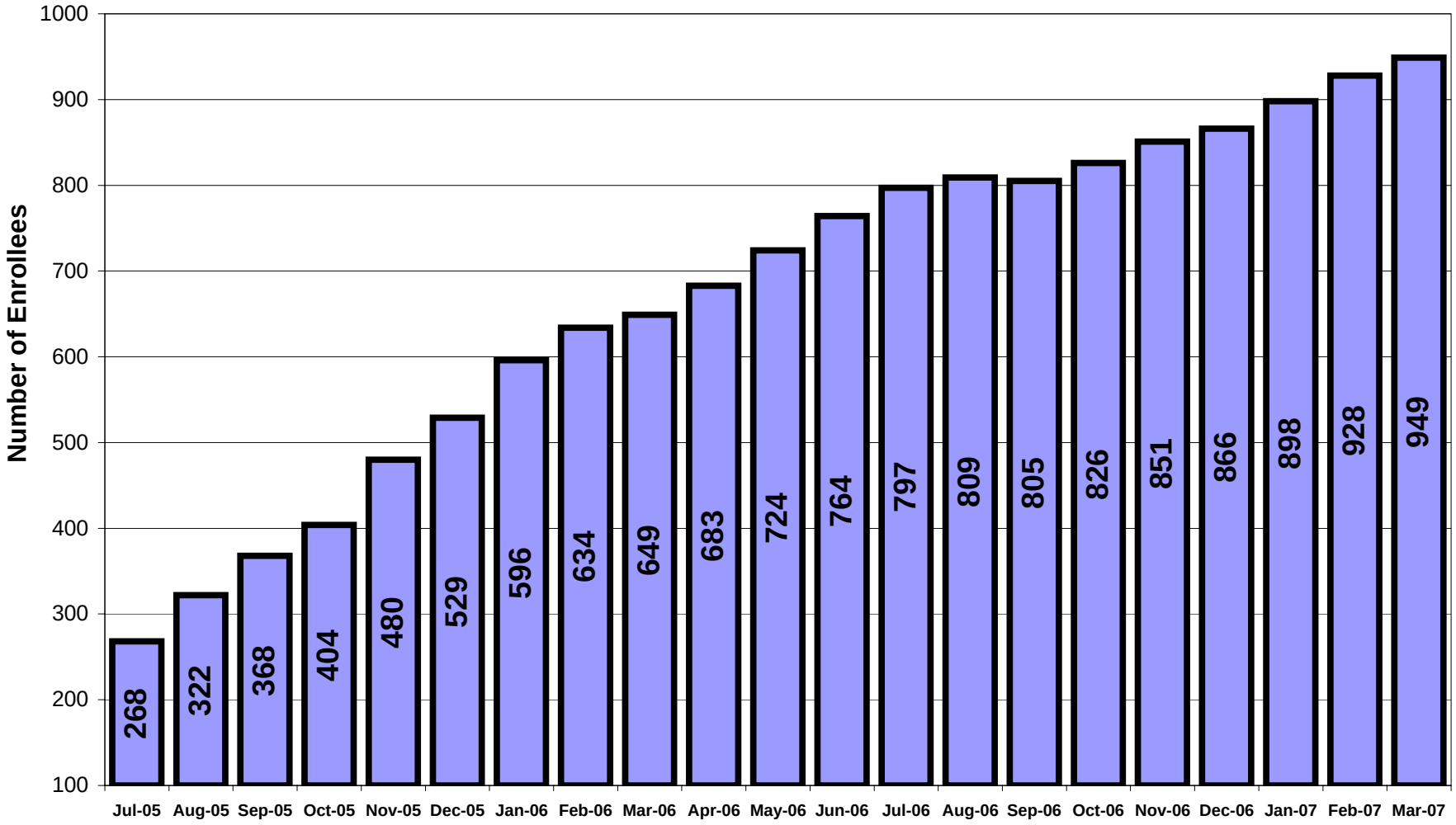
Marty is leading a work committee focused on a "clearinghouse" of credible, trusted, timely information increasing employment outcomes for persons with disabilities. This includes looking at printed material, electronic, web-based, curriculum training, etc. Marty shared information with about 300 people at the Transition conference in Frankenmuth.

Joe and Marty attended the Evidence Based Practices (EBP) program on Building Skills for Supported Employment for People with Serious Mental Illness. David Lynde, Co-director at Dartmouth EBP Center provided the training. This was a values based training promoting early "engagement" in the job search process to capture the energy and interest of the individual.

Joe attended the Centers for Medicare and Medicaid Services conference in Baltimore and attended sessions focused on employment. He also networked with nearly 30 other MIG grantees.

Joe is working with Erin Riehle from Cincinnati Children's hospital to be give a plenary and also a breakout session at the self-determination conference on June 12 in Lansing. He is also working with the Michigan Business Leadership Network to facilitate a presentation to Human Resource workers/employers in the health field here in Michigan on June 13. Erin directs Project Search. Currently, more than 70 people with significant developmental disabilities are working as employees of this hospital through Project Search. On average, these individuals have been employed for five years and earn an average wage of over $8 per hour. Most are working about 32 hour per week and receive full benefits. These employees work in a wide range of positions, often overlooked for people with developmental disabilities.

Michigan FTW Enrollees
March 2007



Freedom to Work Enrollment
By County
2007

County Code	County Name	Beneficiary ID		County Code	County Name	Beneficiary ID
1	Alcona	2		40	Kalkaska	2
2	Alger	1		41	Kent	86
3	Allegan	10		43	Lake	2
4	Alpena	1		44	Lapeer	7
5	Antrim	6		46	Lenawee	13
6	Arenac	5		47	Livingston	8
7	Baraga	1		49	Mackinac	2
8	Barry	2		50	Macomb	55
9	Bay	35		51	Manistee	5
10	Benzie	3		52	Marquette	8
11	Berrien	29		53	Mason	6
12	Branch	5		54	Mecosta	6
13	Calhoun	19		55	Menominee	4
14	Cass	3		56	Midland	11
15	Charlevoix	8		57	Missaukee	2
16	Cheboygan	1		58	Monroe	14
17	Chippewa	9		60	Montmorency	3
19	Clinton	7		61	Muskegon	37
21	Delta	9		62	Newaygo	11
22	Dickinson	5		63	Oakland	76

County Code	County Name	Beneficiary ID		County Code	County Name	Beneficiary ID
23	Eaton	14		65	Ogemaw	1
24	Emmet	6		66	Ontonagon	1
25	Genesee	27		67	Osceola	4
26	Gladwin	1		68	Oscoda	1
27	Gogebic	4		69	Otsego	7
28	Grand Traverse	18		70	Ottawa	17
29	Gratiot	4		71	Presque Isle	1
30	Hillsdale	5		72	Roscommon	4
31	Houghton	5		73	Saginaw	5
32	Huron	5		74	St. Clair	11
33	Ingham	37		75	St. Joseph	12
34	Ionia	3		76	Sanilac	6
35	Iosco	1		78	Shiawassee	5
36	Iron	3		79	Tuscola	2
37	Isabella	4		80	VanBuren	5
38	Jackson	11		81	Washtenaw	40
39	Kalamazoo	58		82	Wayne	80
				83	Wexford	1
					TOTAL	**928**

Issue	*Explanation*	*Potential Solution*	*Action/Timeframe*
PAS/PCS Issue As of today Persons needing PAS/PCS to manage personal needs while at work cannot accomplish this.	Persons needing PAS/PCS to accomplish personal needs are limited at how long during the day they can be away from home. Because they cannot take care of personal needs at work, they end up working less or choosing not to work at all. The FTW law itself prohibits the use of PAS/PCS in the work place, ie "FTW 106a (3) - …and does not include personal assistance services in the workplace."	-Work with MSA to draft language to amend the State Plan. This will be part of our Medicaid State Plan. -The State Plan Language will override the FTW Language. -Mike, Joe and Theresa will work with MSA -If no word on SPA by Friday, June 16, Ed Kemp will initiate contact with CMS to ensure the SPA process is moving.	-Submission expected by early April -May 11 Rough draft submitted to CMS on per Ed + Logan -May 23 Rough draft sent to Adrienne, MIG Grant Officer, for consideration -May23 Mike Head encouraged further MSA action -June 13 Ed Kemp has not heard back from CMS on the cursory review of the SPA. After the whole submission process is complete, which is expected early this fall, the Effective Date for the PAS piece is projected to be July 1, 2006. -June 23 Received email from Nancy Bishop that they have heard from CMS and the PCS State Plan Language is a go ahead with a few clarifications on areas not having to do with the workplace or the community. -July 11 Per Ed Kemp-MSA, an attestation letter stating that a state plan amendment allowing personal care services to be used at work will be submitted in July 2006, has been written. Sue Moran will sign and forward to the MIG for the 2007 Grant submission. -Aug 15 SP Amendment package is expected sent to CMS by the end of August. Notification will be sent to Joe when this occurs. Ed Kemp outlined next steps. 1) There will need to be a bulletin written for distribution. 2) Two issues still need to be resolved: a) # of evaluations necessary, and b) how the Mental Health side might utilize this availability of PAS. -Sep 12 An amendment to increase the reimbursement rate levels for personal caregivers is being submitted to CMS. The amendment concerning PAS/PCS will have to wait till after a meeting with Mike Head, Paul Reinhardt, Pat Barrie, Irene Kazmerski, and others meet to discuss and resolve the mental health side of the issue. -OCT 10- The PAS amendment was sent to

			CMS on September 28th. A draft bulletin for this policy has been created. Joe will send it to Ed Kemp with copies to Susan Yontz and Mike Head. CMS has 90 days to respond. MSA does not anticipate any additional issues. In the meantime we will continue the bulletin and policy process. -Nov 14 We now have a SPA No. 06-16. CMS has sent back questions regarding the Home Help program itself not necessarily involving the PCA/PSA. A response will need to be prepared. Input will go through Mike Head to Ed Kemp. A meeting is planned to be scheduled to work on the response immediately after the Thanksgiving Holiday. -Jan 10, 07 Asked about how the State was doing on responding to CMS inquiries regarding PAS. Ed Kemp was not present at the meeting to give update and no one else had an update. -Feb 14, 07 According to Nancy Bishop of MSA, the responses to CMS questions were sent back to CMS, and we are expecting to hear back from CMS by sometime late February. They have 30 days to respond back. **-Mar 12, 07 CMS responded to the responses from MSA and now appear to have one unresolved question about language in the State Plan Amendment (SPA) that notes that a "flat rate" is paid to adult foster care homes. This will need to be resolved before the SPA is approved by CMS. MSA notes that this will be very challenging to address.**
Case Review/Earnings Level Issue Presently, after 12 months a person earning over SGA – upon their yearly DHS case review, the	DHS defers to PEM 260 for directive as to yearly review and PAM 815 as to guidance on the process of review. DHS Diary Date set for automatic annual review of a person with a disability set at one year. The review looks at earnings, then disability. The current FTW law supports this. The FTW law states eligibility standards in 106a (2) specifically "(a)…. or would be found to be disabled except for earnings in excess	-Working with MSA, and DHS – MRT Division. -Short term solution "interim update" to DHS proposed. -Long-term procedure being determined. - Need to review cases w/out considering disability. -Need to change procedure manual (PEM) manual to disregard earnings	-MSA, DDS/MRT, SSA, & consultants from WI teleconferenced on Feb 9 to determine process -Feb/Mar Mi Job Concerns increased -Mar/Apr advised MSA of MI JOBs concerns - April MSA met with MI Jobs late in April -May 16 Jackie & Theresa provide re-worked forms & created cover letter to MSA -MSA begins 10 day concurrence process and seeks DHS endorsement

person is seen as "not" disabled, and kicked out of FTW because of earnings level.	of the SGA level as established by the U.S. SSA"	consideration in the case of FTW participants - Jackie & Theresa assigned to work with MSA & complement process -Theresa will assure that Linda does receive copies of the documents she needs (PEM 260 & 174).	-Anticipate a July 1st implementation - June 13 Linda stated that she needed the revised version of PEM 260 sent to her, and also PEM 174. Discussion as to process of creating a new form occurred. An ALJ letter was initiated to alert them of this issue so that they could kick it back to MSA and avoid unnecessary hearings. - July 11 MSA will provide Jackie with changes from DSS. They will also provide MIG with the status of the policy and a timeline for implementation. MSA is going to look into pursuing a possible "interim waiver" of disability determination for freedom to work participants impacted by this problem. MSA will obtain a list of possible FTW individuals up for annual review and consider how this may be used to advise local offices so individuals do not receive notices about being ineligible. -Jul 19 MSA, represented by Logan Dreasky, and Linda Kusnier attended MI Job Coalition Meeting to go over the strategy that will be employed to effectively keep adverse actions from occurring in the case of persons whose DHS Medicaid case is up for annual review. At this time Logan explained that a query will be developed to identify the cases for review and a list would be compiled. As a pre-emptive strategy, once the cases are identified, the local office will be informed and the case will have the review date extended by 12 months. This will allow MSA enough time to come up with the appropriate policy to deal with the issue. -Jul 26 MIG Received email from MSA, who stated that with the assistance of DHS, they have developed the query to identify cases with current or upcoming review dates. The plan is to begin reviewing the cases at DCH beginning the week of August 7, 06. ` Any action extending the review dates will be completed by DCH. -Aug 15 No list yet, but should be complete soon. Staff from MSA will manually make the

			changes to review dates through December. The policy should be done by then. The new instruction to MRT will say to disregard income when making the medical review. Sept 12 Joe stated frustration with lack of movement on this issue and underscored MIJobs coalition concerns. Logan and Ed suggested inviting Sue Moran and Steve Fitton to next MI JOBS meeting. Sept 13 Logan made a decision to have Linda Kusnier start reviews of all current FTW enrollees on 9/25. This will be completed by 9/29. She will review each enrollee, select those with Oct, Nov, Dec, Jan, Feb & Mar. review dates and move the review date forward 1 year. Linda will log this data and advise DHS so they are aware of the changes. This way it can be handled within MSA. Logan would have her start this next week, but she's out of the office on vacation. -Oct 10 Linda received the printout for the AD-CARE consumers. The criterion for the printout was more extensive than just those on FTW who needed a review so the list was approximately 800 names. Only 4 individuals needed to have their review dates advanced ahead. About 80% of this list is coded as AD-CARE, and it appears on the surface, that there may have been miscoding errors. Some of these consumers had earned income above the AD-CARE level and likely should be in FTW. -Nov 14 Linda reviewed cases in September and the forwarded the re-determination dates as appropriate. There is a new Joint Manual Process that is slowing the process of getting the necessary new policy in place. Therefore, MSA will continue to work with DHS to extend review dates as necessary. In January 2007, the topic will be brought up again to see where things are at that point. -Feb 14, 07 This issue is still not resolved, therefore Linda is to push review dates forward for six months again. Logan will send Linda an email to see if she has been able to

			complete the process. If Linda cannot get to it before leaving for her time off work, Logan will ask Anne Bialke to complete the push forward of review dates process.
Unearned Income Issue Current FTW individuals receive or achieve unexpected unearned income, placing them in a status with unearned income above FPL.	Some unearned income results as a direct benefit from working, such as: unemployment, workers compensation, and working at higher earnings, thereby increasing the amount of SSDI check received in the case of temporary layoffs or medical leave. Other factors that could cause an unexpected rise in unearned income include the death of a parent, receipt of child support, or receipt of spousal support. FTW Law 106a (2) (c) states, "The individual has unearned income level of not more than 100% of the current federal poverty guidelines." Yet this seems to contradict with 106a (4) (c) which speaks to "temporary breaks in employment that do not exceed 24 months if temporary breaks are the result of an involuntary layoff or are determined to be medically necessary." Because of a person's past work record, the amount of unearned income collected during these temporary breaks from employment may actually bring a person above the FPL threshold and make them ineligible to participate in FTW.	-The benefits derived from working are received as unearned income, ie unemployment, comp pay, disability leave, etc. -The intent is not to be penalizing people who work - Theresa assisted by Joe, will develop list of items to be included in future inclusive FTW disregard for submission to Logan by June 30.	-Early March… Advised Logan & Linda with outline of several different ways that unearned income may impact people, especially during period of non-employment. Joe and Theresa -Mid March… Unemployment is being submitted as a disregard amendment to the Administrative Rules as State Plan supplement per Logan with CMS -Early May Logan noted that other factors impacting unearned income may be considered with a "broad" %'general disregard for current FTW participants **-**Anticipate discussing during June Ed/Logan mtg. -June 13 Good news, the unemployment issue is now a part of the policy in print as of Program Policy Bulletin #2006-010, p6 of 11. Discussed the development of an inclusive disregard that would have items of unearned income that is received either directly or indirectly related to being a benefit of working. -June 30 The list of unearned items with some policy language was developed by Theresa and then forwarded to Logan at MSA -July 11 Members will review the suggested disregards and consider others. Ed Kemp of MSA suggested that we needed to get Mike Head to assist in seeking new administrative policy on disregards. Joe will follow up with Mike if the list is conclusive at the August meeting. -Aug 15 Some discussion occurred. A recommendation was made by Tony to add VA and SSDI death benefits to the second list. Theresa will modify list and send it back to Logan. Also she will look more into the possibility of using a disregard by a percentage amount. Logan informed us that these disregards would be for someone entering as well as already in the FTW eligibility category, because we cannot treat

			people differently. -Sept 12 Nothing has moved on this. Nothing we can do at this time. Need Plan of Action (PLN) on this. Per Ed Kemp there needs to be a meeting with Mike and others on this. Ed will put this on his Friday agenda with Steve Fitton. -OCT 10 The issue was discussed with Steve Fitton. Logan will provide Steve with rationale for each type of disregard before Steve will approve. Theresa provided Logan with some of the rationale that she had and has agreed to assist if needed. -Jan 10, 07 Theresa provided Logan Dreasky with the top three disregards that would be most helpful to people with disabilities that are working and wish to remain eligible for FTW Medicaid. Logan Dreasky will move the list forward to Ed Kemp and Steve Fitton. A questioned rose about disregarding COLAs. Disregarding COLAs automatically seems to occur as a matter of policy within the department. Verification of this fact is necessary. -Feb 14, 07 Tony brought the issue of DAC status and additional unearned income to the group for discussion as a potential addition to our list of disregards. A DAC can be in FTW, then a parent passes away and now they can receive SSDI under that parents record. Say that the parent SSDI amount puts their unearned income over the FPL. Realizing that this is not income generated because of an individual's work record, but instead is based on their parents work record, we still do not want to punish a participant because of a rise in unearned income due to work. There seemed to be some debate as to how often; or if this would ever occur. The issue needs to be flushed out a little more. Bridget and Theresa will flush this out more for the next meeting.
Aging Out Issue FTW participants	FTW Law specifically states in 106a (2)(b) "To be eligible, "the individual is at least 16 years of age and younger than 65 years of age."	-One course of action could be to try to pass a Medicaid Buy-In under the Balanced Budget Act as other states	-NCHSD informed us that Connecticut is attempting to pass a BBA as of this year to address the "aging out" issue. Anticipate

approaching age 65+ accumulating resources, savings, retirement, etc. must now dissolve these resources in order to retain Medicaid eligibility.	Michigan's Medicaid Buy-In Law is authorized under the TWIIA, which has an age limit for participation of 16-65.	are attempting to do. The Balanced Budget Act allows for all ages to participate but has other restrictions as to income earned and savings. -Theresa will discuss with NCHSD and look into which states either have done this or are about to accomplish the passing of both. -Theresa will follow up with NCHSD and/or Connecticut on this topic.	results from CT by early July. -July 11 Neither Theresa nor Joe has heard anything back from Connecticut on their progress. Theresa will make contact with Connecticut and other sources to look into this issue and possible resolutions. -July 13 Theresa received notification that Connecticut efforts to pass a MBI under the BBA have been successful. More details to follow. -July 17 CT did pass legislation allowing the state to cover persons who are 65 and older using the Balanced Budget Act. According to their policy analyst, Larry Carlson, their proposed State Plan Amendment will add a Balanced Budget Act group to their Medicaid Buy-In. The BBA has no restriction of participation according to age. CT can now cover these individuals provided they meet the other provisions (disability, employment, and financial of their buy-in eligibility criteria.) CT. will be using 1902(r)(2) in order to extend the TWWIIA income and asset limits to the BBA Group. -Sept 12 Theresa is working on a concept paper for this issue. Ed Kemp said he would like a copy of it sent to him and Logan for discussion purposes next time. He also said that we would need to draft Bulletin language for this issue. Theresa said she would add that to the concept paper, and solicit Jackie's help with Bulletin language. -OCT 10 Theresa presented work plan on this issue, and is presently drafting concept paper outlining options to resolving this issue. Once a decision is made on a course of action, Theresa will draft the accompanying bulletin.
Premium Issue The current FTW premiums fees are seen as "cliffs." The variance in premium amount leaves big differences from one	The FTW Law allows for Medicaid Buy-In premiums to be on a sliding scale. Specifically the FTW Law states in 106a "(5) (c) "the Premium sliding fee scale shall have no more than 5 tiers." An unintended consequence of setting the fee scale as MI did (using an SSI methodology for counting income) resulted in individuals	- Consider a MSA Administrative Policy Change in the existing current premium fee scale. -One Suggestion includes changing to a % scale for individual income level; or go from 100% FPL To 250% of FPL to begin paying premium. - Another possibility would be to	-Aug 15 It was suggested that we consider using % for eligibility into the program. And it should also be noted that % was suggested here as a way to make premiums smoother from one level to the next. -Sept 12. It was suggested by Tony that we might want to look at and compile suggestions using different premium scales or

level to the next, which can be triggered by a simple .50 cents increase in pay.	having to earn around $4,000 a month before paying the first level of premium, which was set at $50.00.	switch to a sliding scale based on percentage of countable income. -Some states have premiums that start at the point of any earnings and/or may include unearned income	methodology for premiums. Theresa will assist by providing an analysis from NCHSD on what other states have for their premium systems.
Marriage Penalty Issue The FTW participant's earnings are "deemed" to the spouse and the spouse becomes ineligible for Medicaid and other supports.	The issue of deeming is a problem for FTW participants who have a spouse receiving supportive benefits, such as SSI, due to a disabling condition. A part of the working spouses' income is deemed to the other spouse. This results in the other spouses' benefits possibly being reduced or eliminated.	-This is a federal challenge within SSA -The WIAG group meets in Chicago and this is a topic they are considering. Tony Wong, Karen Larsen, & June Morse participate.	-Aug 15 A question was raised, why we couldn't use the provisions in 1902 to specify this group individually, and make a State administrative rule that would eliminate the problem of deeming between spouses. Logan referred us to a piece of guidance issued from CMS that may be of help. More research to be done in this area. Sept 12 Tony is going to write up a possible state solution to this Federal problem using the 1902 (r)(2) provisions. He would like some feedback on a document he is preparing for the WIAG committee.
Part B Premiums Issue Some FTW persons become responsible to pay the Medicare premium for Part B without being advised of this impact.	The state DHS policy FTW, PEM 174, clearly states,"a person eligible for medical assistance under FTW is not eligible for ALMB." FTW participants may be required to pay Part B costs when they achieve certain earnings levels. Currently Individuals are not made aware of this before switching to FTW.	-Theresa will further research potential implications of this factor within the FTW program -Consider whether a change in Administrative policy is needed -Need to develop method to inform participants that they may be required to pay their Medicare Part B premiums as they begin working.	-June13 MSP premiums were discussed briefly as the issue also involves concurrently eligible for ADCARE. Linda concurred with Theresa's findings that people did not have to pay Medicare Part B premiums because of switching to FTW, but because of a rise in their income as a result of working. -Jan 10 We acquired information at this meeting that there is a new sliding scale to part B premiums with costs starting at $93.60 plus $12.50 and with a scale going up from there. At this time there doesn't seem like there would be an impact for our current FTW participants, but that may change if and when we have participants in the higher income brackets.
Waiver Issue People are asking	People want to be able to remain within a waiver, work, and participate in FTW, but they have been told they can't. People prefer waivers because of the PSA/PCA services.	-Discussed with Pam McNabb & Jackie Tichnell. Eligibility would depend on slots and earnings? - Mike Head noted that FTW was an	-Anticipate discussion of this topic during June Ed/Logan meeting. -June 13 Logan and Linda acknowledged receipt of the overview memo from Jackie

about being in FTW while using waivers.	Waivers have a higher income limit to be economically eligible than other Medicaid programs. FTW is an eligibility category and by using the "Freedom Accounts" a person should remain or be eligible for the MI Choice Waiver.	eligibility Category, whereas the MI Choice waiver is a Program Category. -May 18…Jackie forwarded an overview of why we believe FTW should be able to work in conjunction with this waiver	suggesting that a person may utilize both MI Choice Waiver and FTW eligibility at the same time. MSA will further review the memo, meet with Bob Orme, waiver policy analyst and make a suggestion to Ed on how to proceed. -July 13 Both FTW and MI Choice are a Medicaid Eligibility. The issue appears to be in the interpretation of policies. MSA will discuss with both DHS and waiver agents. -Aug 15 regarding a discussion on the term "Nursing Home Level of Care" and how this plays into people on the My Choice waiver using FTW. Some discussion needs to occur on the interpretation of long term care terminology and the interaction between the MICHOICE Waiver and FTW. Ed will meet with Bob Orhm and others. Sept 12 Per Ed Kemp , once meetings begin on SPEs needs to be set up with Bob Ohrm and Ed Kemp said that the topic of "Nursing Home Level of Care" NHLC could be one of the first issues to be discussed and resolved. We want the waiver agents to understand that NHLC can be delivered in the community. Remember Olmstead. And that in some cases people with that level of health needs still live active lives including working. -OCT10 Ed was not in attendance. Joe will check with him individually to see where things are on this issue. -Nov 14 Ed said Jim Schwartz will discuss and advise Waiver Agents that a person can be on both a MI CHOICE Waiver and FTW at the December Waiver general meeting. -Jan 10, 07-Mike Head met with Ed in December to address this. Logan did not know if this had formally been addressed. Joe will check with Ed. -Feb 14, 07 We can now celebrate success on this issue. People can now participate in both the waiver and FTW at the same time. Joe presented a copy of a memo to the waiver agents giving them direction on the new policy.
Economic	People with disabilities work to make money	-Need to do research on what it would	-Feb & April "Think Work" summits suggest

Earnings Issue SSDI recipients that are FTW enrollees remain discouraged from earning over SGA until a person can minimally replace their SSDI check. Ties into the Federal SSA action on SGA. People are unlikely to work in order to have less $ in their pockets.	just like anyone else. Individuals are commonly unwilling to accept work that won't minimally replace their check. It costs PWD money $ to work, in some cases people with disabilities incur large expenses in order to work. In addition, individuals remain concerned of the future need of medical coverage. Some progress has been made in this area through the TWIIA and reinstatement of benefits provision within.	take to eliminate SGA and allow persons to wean off benefits slowly. -Work with the MI JOB Coalition and others working towards a solution to the issue of SGA - PWDS need to gain skills to qualify for a higher paying job, so they can earn enough to take the leap of faith off the system.	growing effort by Mi Jobs Coalition to seek demonstration/pilot grant from SSA to disregard SGA as a standard for persons with SSDI.
Deductible Issue As of January 2004, PWD may have been put into Spend-Down eligibility category (now referred to as the Deductible Program) instead of being referred to the FTW eligibility category.	As of January 2004 through August 01 2005 (Prior to the institutionalization of the LAO2 prompt), PWD may have inadvertently been put into spend-down (now referred to as the Deductible Program) when applying for Medicaid benefits because of having earned income combined with unearned income that placed total earnings over the FPL. Some of these individuals should have been FTW participants.		- July 13 Concern was expressed as to what if anything can be done to capture persons who were missed. -Aug 15 Additional discussion occurred. No action -OCT 10 There was some discussion as to what/who this population is. Linda Kusnier is working on the December 2003 persons that were spend down prior to January 2004 and would have been FTW persons except for the implementation date. Tony was thinking this was the same group of persons. Logan will pursue with Linda

AD Care Issue PWDs that come in to apply for Medicaid and are working below 100% FPL are automatically referred to AD Care.	It is the policy of DHS to place eligible individuals into the most beneficial MA category for the person. Yet, some individuals with disabilities who have jobs and are actively working are placed into ADCARE rather than FTW. These individuals have a combined income below FPL. The benefit of placing working PWDs to FTW would increase the program enrollment numbers and bring more federal grant dollars to the state ultimately providing greater opportunities to individuals with disabilities.	-Take a look at DHS policy and procedures and determine if changes are needed. If so, make recommendations to MSA. Theresa and Jackie -Study the challenges of transferring working persons with disabilities from ADCARE to FTW to be sure that no harm would occur (recall that some would then need to pay the Part B premium of $88.50/mo.) *People will only have to pay their Part B premium as their income rises above the poverty level. At that point they would no longer be eligible for ACARE or the Medicare subsidy because they would be over income.	-June 13 Discussed briefly about the possibility of simply moving all eligible ADCARE people onto FTW to allow these individuals to take full advantage of the FTW program. Ed Kemp did not feel that anything would prohibit this from being done. Estimated time to completion, approximately two months per Ed Kemp -June 13 additional note Per Logan…when creating the hierarchy of Eligibility for the new bridges system FTW was placed above ADCARE. Additionally the new bridges system will allow targeted letters to be mailed to certain Medicaid eligible persons -July 11 MSA indicated that the actuarial division is concerned about moving AD CARE individuals to FTW. Joe will ask Mike to pursue this with Ed Kemp. Ed is going to talk with the actuarial department as well. There was discussion about the issue of choice for persons "moving" from AD Care to FTW. Additionally it was also noted that consumers do need to be made aware that they have FTW, and what advantages for self sufficiency that offers to them. Possible methods of informing consumers once they are transferred to FTW were discussed. -Aug 15 Ed will get this topic on the agenda for his next meeting with Mike as the LTC department head, along with others. There are an estimated 74,000 ADCARE participants. -Sept 12 Estimate number of ADCARE beneficiaries with income from earnings is 6161. Ed Kemp will get this topic on the Friday agenda with Steve Fitton. -OCT 10 Julie is to provide associated dollars with this group. MSA administration does support the concept of moving these 1consumers to FTW. Mike Head concerned about the timing. It is necessary to do this soon so that we can use this for future Medicaid funding.. Logan will develop a plan to get this process done. The importance of educating consumers to make an informed

			choice was one again stressed. -Nov 14 Joe shared a draft memo to advise AD CARE participants. Joe will edit again and share it at the December meeting. -Jan 10 Joe submitted a letter collaboratively written with assistance of Jackie and reviewed by Theresa to go out to the 6000 + people that are being considered for transition from ADCARE to FTW. The letter explains what FTW is and how it can benefit the individual. Most importantly, it will tell them where to get more information. Jackie suggested that it would be helpful if the letters sent out included the WIPA brochure. Discussion of transferring people over to FTW from ADCARE went on. There was lengthy discussion regarding the issue of married AD Care consumers. What is the impact on each of the partners? Currently, the FPL used for AD Care would be as a family of two (a higher level than family of one). The FTW person would need to have unearned income below 100% of FPL. Per Logan Dreasky, it was determined that this would not immediately impact the AD Care spouse who would continue to be considered in a family of two under AD Care. There would be no initial impact, until there were more earnings in the AD Care group. If both people had unearned income below FPL and earnings (even very small earnings) then they'd both be FTW eligible and remain Medicaid eligible as long as they individually met FTW criteria. And it was also suggested to included with the letter an option of choice by saying "if you do not wish to participate in freedom to work Medicaid call (case worker or MSA?) The only challenge to this language is that written this way the letter requires an affirmative rather than a passive response from individuals if they do not wish to participate in FTW. Next step Joe will work with Tony re: use of WIPA brochure/contact info, letter will be rewritten with the recent input and forwarded to Logan for his review.. When

			approved, MSA will handle the mailing out of the letters. -Feb 14, 07 New draft of letter was submitted and did not include income grid. The new version was well received and will be our final draft for submission to be sent out along with a WIPA brochure, as the group decided that this was useful information to include. **-March 14 Again the question was raised by Logan as to the viability of just switching all ADCARE consumers who have income from work over to the Freedom to Work category in one step. According to present state DHS policy; putting people in the most advantageous Medicaid category for their benefit; procedurally the Freedom to Work is the most beneficial category for people with disabilities who work.**
Freedom Accounts Issue FTW enrollees are not aware of Freedom Accounts and commonly don't know the benefits of utilizing these accounts to build savings or increase earnings.	The advantage to Freedom Accounts is that PWDs can set aside income to save for things they need, and still qualify for Medicaid benefits and medical coverage under the MA program.	-Determine how to build awareness among FTW enrollees to promote increased earnings & savings while retaining needed benefits.	**- July 11** Logan Shared that MSA is working with DHS on the Bridges project and that the Bridges System has a "placeholder" to trigger the system designers to allow for Freedom Accounts in the new system. This would tell the system to automatically put savings into Freedom Accounts during the budget creation process by DHS workers. MIG needs to work with MSA on developing o process to handle this issue with DHS. Jackie, Theresa & Joe will meet on 7/20/06. **-7/20/06** Jackie, Theresa and Joe met and developed a plan to address this issue through creating a form and making changes to the PEMs. -Aug 15 Theresa reported that she has located within the PEMs a DHS Form that will serve the purpose of designating freedom accounts by consumers of DHS services. She also has drafted new PEM language and directions for the use of this form. Theresa is in the process of going through the PEMS to see where modifications need to occur to affected PEMs, and is drafting a memo on this to be submitted with the suggested changes. -OCT 10 Theresa shared a draft Bulletin

			announcing this policy. She provided Logan with a copy. MSA will review and provide the office with comments. Tony suggested adding a section on consumer responsibilities and consequences to the bulletin and the brochure he is working on. Theresa suggested modifying DHS Form 503 Asset Verification Form to include designation for Freedom Accounts, creating a new DHS Form for FTW. A suggestion occurred to modify the FTW DHS Form since Freedom Accounts can also include money from income. Make it a similar but New Form with its own Form Number.
SSA 1619 transition to FTW Presently smooth transition to FTW is not assured.	Persons presently in 1619 status may earn or save their way onto FTW, but are fearful to take that leap because they are unsure that transition into FTW Medicaid will be a seamless process.	-Research possible ways to address MA policy to allow this transition to be seamless.	-TBD
Working from Home and HUD Housing	Persons living in HUD housing are told that they cannot engage in business activities out of their home. This severely limits some employment opportunities for PWDs.	-Theresa will check HUD policy and also with a few contacts she has within the advocacy field that often helps PWDs with housing issues regarding subsidized housing.	-June 16 Ref Jackie Blankenship (MSHDA) thru Sue Eby (MDCH) thru Glen Ashley (MDDC-MDCH) **HUD Regulations:** 24 CFR 982.551 Obligations of Participant states (h) Use and occupancy of unit - (1) The family must use the assisted unit for residence by the family. The unit must be the family's only residence. (5) Members of the household may engage in legal profit making activities in the unit, but only if such activities are incidental to primary use of the unit for residence by members of the family. **24 CFR 982.516** discusses family income and composition; and 24 CFR Part 5.609 discusses family income; 24 CFR Part 5.611 discusses adjusted income **HUD's Housing Choice Voucher Program Guidebook says this about income inclusions –** "The net income from operation of a business or profession. Expenditures for business expansion or amortization of capital indebtedness shall not be used as deductions in determining net income. An allowance for depreciation of assets used in a business or profession may be deducted, based on straight line depreciation, as provided in Internal Revenue Service regulations. Any withdrawal of cash or assets from the operation of a business or profession will be included in income, except to the extent the withdrawal is reimbursement of cash or assets invested in the operation by the family."

Michigan First - Health Care Program	Does this new waiver have any impact on the Freedom to Work Program?		-July 13 Jackie Tichnell contacted Susan Yontz. What we know so far is that it is an 1115 waiver, there is no draft available to share, and there is no template. Susan will let people know that we are interested in learning more information and she will get back to us. -August 8 Theresa has done some research into this and drafted a memo giving the message that from all materials so far there appears to be no adverse effects to FTW participants. This new MI health program may in fact offer health care to people with disabilities who wouldn't otherwise have access to health care.
FTW training in DHS offices (and elsewhere) to NOT include References to not being on a Spend Down/ Deductible.	The current training module used by DHS makes reference to FTW not being for people on the deductible Medicaid program.	The fact of people being on a deductible being the reason for exclusion from FTW is really not true. The qualifying eligibility criteria used for FTW is the same as for ADCARE eligibility, using an SSI category income breakdown.	
Issue regarding the use of or Lack of use of IRWEs by PWDS due to many systemic problems.	1.There is no clear rules or process available to the public or with in the SSA Department that persons can use as guidance in determining whether they have potential IRWEs. 2. When PWDS who are aware of the POMS or are working with a knowledgeable Social Worker and therefore they have a list of IRWEs to turn in. They are treated as if they are stealing or trying to get something they don't have a right to. 3. When PWDs are working with knowledgeable WIPAs etc. and turn in there IRWEs, they receive no correspondence or feedback from SSA. And on most occasions no one even applies the IRWES to the case. And if SSA does. SSA never tells anyone.	There needs to be an administration process and documentation flow process put into place here. Along with an appeals process. The lack of these thing clearly shows why the numbers are so low in people using IRWEs.	
FTW and Family Size Eligibility	When FTW eligibility is considered for people with disabilities, we look at the individual. The issue of what is the individual is a member of	-We need to decide if we can look at family size relative to income eligibility.	**-<u>March 14, 07</u> Mr. Steve Fitton , and Mr Paul Reinhart, and Ms. Jackie Doig were guests at the meeting this day to discuss**

Issue	a family of two and the working spouse is currently receiving medicaid under ADCARE or some other category?	-We need to consider the impact on other people who now may be eligible where they were not before.	**this particular issue as it arose with a married disabled consumer who wished to be in the Freedom to Work category. Currently, he receives Medicaid through the ADCARE category. Between the consumer and his spouse their combined income is under the FPL income level for a family of two. Although the individual alone has unearned income above the FPL for an individual. The question was raised of whether or not to allow an individual who meets the 2 per person standard of unearned income less than 100% of FPL criteria into the FTW category. Paul supported it. Steve said he also would support it, but he would like to see some documentation on the implications of allowing this. Logan said that this would cause some issues with the way the law is written and with CMS and the State plan.**

Michigan Quality Community Care Council Report
to the Consumer Task Force
March 21, 2007

Numbers

As of the end of February 2007, there are 566 approved providers on the QC3 Registry and 443 consumers used our services.

Training, training, training

The dementia trainings scheduled in Southfield, Detroit, and Highland Park filled up in a day and a half, and the Bay City training filled up in less than one week. We have not yet sent the mailing for the last dementia training of the fiscal year which will be in Holland. These trainings are the ones entitled: "Working with People with Dementia: Environmental and Communication Strategies".

The dementia training at Lansing Community College is also full. Since we did one in Lansing last year, this year it is a different course. This course is "Working with Someone with Dementia: Assessing Caregiver Interactions". The materials and instructor for all of these dementia trainings are free of charge to us thanks to a grant through the MDCH Bureau of Mental Health and Substance Abuse.

Of the remaining 17 Adult Abuse and Neglect Prevention (AANP) trainings we have planned through the end of June, 6 are already closed to RSVPs.

We have scheduled the CPR/First Aid trainings for the Lansing Area. There will be two Saturday trainings at our offices. The target area for the Lansing based trainings is: Clinton, Eaton, Ingham, Ionia, Livingston and Shiawasee counties who are on the Registry and requested CPR/First Aid training.

We are still looking at sites in Wayne County for the same training. For any of the CPR/First Aid trainings, we will cover the cost of the class, mileage, lunch and snacks. There are no stipends for these trainings.

Other

CMS decided to award Michigan an intermediate Workforce Technical Assistance grant. The technical assistance will be aimed at determining why there are regional differences in the number of consumers and number of providers who use our services. Thanks to the team who made this possible. The team included Tanya Haney (QC3), Bob Orme (Medicaid), Cynthia Farrell and team (DHS), Jackie Tichnell (OLTCSS), and Lauren Swanson (OSA). Hollis Turnham also provided assistance.

The Consumer Peer Mentors have finished their initial training. The next training cycle will focus on training the Consumer Peer Mentors to be trainers for the Consumers as Employers Training.

We are getting ready to interview and select our next set of Provider Peer Mentors. Provider Peer Mentors have to be able to do at least six of the approved Home Help services, and it has to include IADLs and ADLs. They also must be a member of the QC3 Registry.

Long Term Care Connections Logic Model Action Plan (Draft March 19, 2007)

The goal of the project is to establish ADRCs to serve as a comprehensive resource on long term care and provide information and assistance in accessing services, planning for long term care financing and delivery, benefits outreach and proactive choice counseling for the general population.

The Michigan Long Term Connections Provides comprehensive, reliable, unbiased information to consumers, caregivers, and providers on accessing long term care services.

Original Grant Goal #1: Offer consumers the opportunity to explore a wide range of long-term care options in order to develop individual plans of care based on informed choice

Original Grant Goal #6: ADRC/SPE operations demonstrate cultural competency

Activities/Process	Outputs	Process Measures	Outcomes	Outcome Measures
Develop outreach standards. Develop marketing plans for each MILTCC site. Implement outreach activities to market LTCC to community partners and consumers.	Standards Marketing plans Presentations Media Releases	Local outreach efforts use standards Activities planned for local outreach *Number and types of outreach activities*	Outreach campaign reaches economically and culturally diverse populations. MILTCC is a recognized source of LTC Information. Community partners refer consumers to MILTCC.	% respondents in RDD survey familiar with MILTCC *# and % of population served based on census figures (new and repeat)* *# of Contacts to by referral source* *# calls to MILTCC before and after marketing campaign, press event, etc.*
Develop community education strategy. Deliver community education campaign/events.	Community education strategy Community education campaign/events	Local community education efforts utilize strategy # and type of community education events	Community members are more knowledgeable about LTC issues. **This should be more specific. What will the campaigns focus on?**	% respondents in locally focused RDD or other survey familiar with LTC issues
Develop policy regarding distribution of materials advertising the services of particular providers. Develop/collect consumer education materials	Provider material policy Consumer education materials	Description of excluded materials Materials	Consumers find the information they receive to be reliable. Consumers find the information they receive to be accurate. The information shared with consumers is comprehensive. The information shared with	Response to consumer survey questions Servicepoint records

Items in italics refer to ADRC-MDS/SART Data Elements

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			consumers is unbiased. ***Operational definition of 'unbiased'?***	
Develop provider resource information template for Servicepoint Develop standards for resource information in Servicepoint Create, maintain, and update resource database according to standards.	Resource database Resource information standards Resource records	Standard information is documented on all providers Standards # of resources Types of resources	Consumers were linked with resources within their region. Consumers considered information to be culturally appropriate. Consumers receive information in a timely way.	
Train staff on information in the resource directory. Train staff on consumer education materials available through MILTCC.	Training materials	*# of trainings* *Type of training*	MILTCC staff are knowledgeable about the resources available in the directory. MILTCC staff are knowledgeable about the available consumer education materials.	Response to training evaluation survey
Provide information and materials educating consumers on how to evaluate providers in meeting long term care needs.	Consumer Education Materials	*# of information packets mailed to consumers* *# hits on consumer guide webpage per month*	Consumers have the information they need to apply for, evaluate, and select long term care services. Consumers find the LTC information provided by MILTCC useful when making choices.	Response to consumer survey questions.
Provide information to consumer about planning and self determination with long term care services.	Consumer education materials	# of brochures provided # of face to face conversations # hits on web site	Consumers have the information they need about planning for long term care services. Consumers have the information they need to make their own decisions.	Response to consumer survey questions

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Connect consumers to community experts to provide information related to special needs of consumers. Distribute special needs guides to appropriate consumers.	Resource directory referrals Mailings	# referrals # and type of consumer guides available #of guides mailed to consumers # of hits on website	Primary and secondary consumers with special needs have the information they need about specialized resources. Primary and secondary consumers with special needs find the information they received useful when making choices.	Response to consumer survey questions
Connect consumers with education providers and resources regarding health, chronic disease, and elder safety. Distribute information related to optimizing health, managing chronic disease, and elder safety.	Resource directory referrals Mailings	# of referrals # of resources available # of guides mailed # of hits on website (if available)	Primary and secondary consumers have the information they need about activities and behaviors that contribute to better health. Primary and secondary consumers used the information they received to optimize their health, manage chronic conditions, and increase their safety.	Response to consumer survey questions
Connect caregivers with resources related to their needs and roles. Provide caregivers with special information related to their needs and roles.	Resource directory referrals Mailings Meetings (face to face or phone)	# of resources available Types of resources available # of guides mailed # of hits on website	Caregivers have the information they need about the caregiving role, how to support the consumer, and how to protect their own physical and mental health. Caregivers find the information they received useful when helping their loved one and themselves.	Response to caregiver survey questions

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The Michigan Long Term Connections Project works towards a goal of seamless efficiency in assisting consumer and families with long term care needs. **Original Grant Goal #2: Faster access to services through streamlining the multiple eligibility and assessment processes**				
Activities/Process	**Outputs**	**Measures**	**Outcomes**	**Outcome Measures**
Convene Interagency Workgroup to share information and discuss ways to develop shared assessments to avoid duplication in Level of Care determination for consumers. **Review carefully** **Describe other activities, e.g. 'Develop and implement electronic universal assessment'**	Electronic universal assessment **Note: which are performed by everyone or selected agency**	*Flow Chart of clinical eligibility process pre and post MILTCC*	There is a shared understanding of process across the long term care system (i.e., MSA, OSA, DHS, DCH). Level of Care determinations are completed in a timely manner. Level of Care determinations are processed accurately. **Note: Do we want to define a level of accuracy? Is there any way to know this?** Ask Nora for suggestions.	Response to stakeholder survey questions Response to consumer survey questions Time to assessment completion is improved from baseline measures. **Is this feasible?**

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The Michigan Long Term Connections Project works towards a goal of seamless efficiency in assisting consumer and families with long term care needs.

Original Grant Goal #2: Faster access to services through streamlining the multiple eligibility and assessment processes

Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
Convene Interagency Workgroup to share information and discuss ways to develop shared functional modular assessments to avoid duplication for consumers. **Review carefully** **Include more description of activities, e.g. 'Develop and implement functional modular assessment process'**	Modular Assessment Collaborative Assessment protocol **Note: which are performed by everyone or selected agency**	*Flow Chart of clinical eligibility process pre and post MILTCC*	There is a shared understanding of process across the long term care system (i.e., MSA, OSA, DHS, DCH). Functional assessments are completed within mandated timelines. Consumers feel assessments are completed in a timely manner.	Response to stakeholder survey questions Response to consumer survey questions Time to assessment completion is improved from baseline measures. **Is this feasible?**
Convene Interagency Workgroup to share information and discuss ways to develop shared assessments to avoid duplication in financial eligibility determination for consumers. **Review carefully** **Include more description of activities, e.g. 'Develop and implement universal, multi-purpose financial assessment process'**	Electronic multi-purpose financial eligibility determination	*Flow Chart of financial eligibility process pre and post MILTCC*	There is a shared understanding of process across the Long term care system (i.e., MSA, OSA, DHS, DCH). Financial eligibility paperwork is completed within mandated timelines. Consumers feel financial eligibility is assessed in a timely manner.	Response to stakeholder survey questions Response to consumer survey questions Time to paperwork completion is improved from baseline measures. **Is this feasible?**

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The goal of the project is to establish ADRCs to serve as a comprehensive resource on long term care and provide information and assistance in accessing services, planning for long term care financing and delivery, benefits outreach and proactive choice counseling for the general population.

The Michigan Long Term Connections Project works towards a goal of seamless efficiency in assisting consumer and families with long term care needs. **Original Grant Goal #2: Faster access to services through streamlining the multiple eligibility and assessment processes**				
Activities/Process	**Outputs**	**Measures**	**Outcomes**	**Outcome Measures**
Build relationships with providers representing special constituencies to discuss opportunities to work together and to build resources for consumers. **Are other activities going to take place, such as developing provider training opportunities?**	MOUs with representatives from agencies New resources for consumers	# of MOUs Listing of partner groups Listing of new resources	MILTCC staff and partners understand the specialized needs of consumers. Consumers with specialized needs receive the support they need to connect with appropriate services and supports.	Response to staff survey questions Response to stakeholder/partner survey questions Response to consumer survey questions
Develop strategy to share Servicepoint consumer information with contracted providers, if feasible.	Servicepoint consumer information	(Listing of Shared data fields)	Providers use Servicepoint. Consumers do not experience duplicate requests for information.	Servicepoint records Response to consumer survey questions
Promote flexibility to allow co-location of agency staff and geographic deployment within MILTCC region.	Location of MILTCC staff	Percentage of central and decentralized staff	Consumers are able to access multiple services in the same location. Consumers feel that MILTCC offices are conveniently located.	Length of time to record/assessment completion. **Is this feasible?** Response to consumer survey questions.

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The Michigan Long Term Connections Project facilitates Access to Services through the use of appropriate information, assistance in determining eligibility and options counseling.

Original Grant Goal #1: Offer consumers the opportunity to explore a wide range of long-term care options in order to develop individual plans of care based on informed choice

Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
Staff at MILTCC sites learn about community needs assessment tools and strategies. Complete community needs assessment / environmental scan. Share results of needs assessment/ environmental scan with policymakers and other officials.	Listing of tools and strategies Community report	Evaluation of assessment. Summary of resources, needs, challenges, & success.	Board members and MILTCC staff feel the results of the needs assessment are accurate and useful. The board and MILTCC staff use results to make decisions and to inform planning. Policymakers, providers, and stakeholders find the results of the needs assessment timely and useful.	Response to board survey questions. Response to staff survey questions. Response to policymaker survey questions.
Develop standards for information and assistance, and Options Counseling Train staff in standards, procedures, and protocols to assist consumers. Train staff in I&A, Options Counseling, financial eligibility	Standards Training manuals Training plan Trainings	Listing of standards # of trainings held #of staff trained Staff satisfaction with training	Staff understand the material presented. Staff feel they can apply the information to their work. Staff serve consumers in a way that is consistent with	Response to staff training survey question. Response to consumer survey questions. Response to stakeholder/partner survey questions.

determination, and functional assessment.			their training. Staff demonstrate cultural competence when serving consumers. Consumers and providers trust the expertise of MILTCC staff.	
Consumer calls are received and addressed appropriately. **NOTE: do all calls go through an operator first or do some I&A people answer phones?**	Case records	*Total # of Contacts made to MILTCC* # providers, consumers, caregivers calling # of people who received each type of service. # people with completed and open calls	Consumers and providers felt they came to the right place for information and assistance. Consumers would use the MILTCC services in the future as needed.	Response to consumer survey questions. **Note: Calls coming into the MILTCC may be completed by I&A counselors or Options Counselors. Many of the same measures will be used regardless of who completes the call.**
MILTCC staff provide consumers with the information and assistance they desire. MILTCC staff use factual information to develop referrals.	Case records	*Total #Individuals receiving I&A* # and types of information delivered to consumer based on I&A request # of referrals made by I&A counselor by type of service & funding type # repeat calls	Consumers received information that was specific to their needs. Consumers receive the information and assistance they need to access the services they desire. **There is more**	Response to consumer survey questions.

			overlap here with the Information goal – we can repeat outcomes here, but I don't think it's necessary.	
MILTCC staff provide options counseling to consumers who seek it.	Case records	# consumers engaging in options counseling	Consumers receive the counseling they need to access the services they desire. **Can we use the word 'identify' instead of 'access'?** Consumers develop a trusted relationship with the options counselors. Consumers felt options counseling helped them set goals. **There is overlap here with the 'Consumer driven' outcome.**	Response to consumer survey questions.
MILTCC staff complete necessary paperwork for financial eligibility determination for those consumers who seek it.	Case records	*Total # Individuals receiving Financial Eligibility Assistance* *#of financial eligibility determinations for those*	Consumers who wanted financial eligibility assessment received the assistance they needed to	Response to consumer survey questions Case records

		over and under age 60 *#enrolled in Medicaid or other programs* *Institutional Care*	successfully complete the necessary paperwork within mandated timelines.	
MILTCC staff help consumers attain Level of Care determination.	Case records	*# of Level of Care Determinations for those over 60 and under 60 (Initial, Change in condition, Recertification)*	Consumers who wanted or needed LOC determination received the assistance they needed to successfully complete the assessment processes within mandated timelines.	Response to consumer survey questions. Case records
MILTCC staff conduct caregiver assessments.	Assessments	# of assessments completed Types of needs articulated	Caregivers feel their needs are understood by MILTCC staff. Caregivers feel involved and supported by MILTCC staff.	Response to caregiver survey questions
Consumers are monitored through follow up	Case records	# of follow up calls from consumer to MILTCC # of follow up calls from MILTCC to consumers Timing of follow up calls Number of consumers	Consumers received what they needed to connect with services and live in their residence of choice. Consumers received what they needed to address new needs	Response to consumer survey questions.

		who chose various follow-up options	through follow up calls.	
Target individuals at risk for lack of choice in community based care setting due to unstable community placement due to precipitous care event, eminent hospital discharge, lack of knowledge and choices, or current placement in nursing home setting.	Identification of targeted individuals.	Number of consumers transitioning from one setting to another	Consumers in targeted populations receive the information, assistance, and counseling they need to access the services they desire and live in the residence of their choice.	Response to consumer survey questions.

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The Long Term Care System is a consumer driven system allowing consumers the desired level of control over their residential setting and care choices. **Original Grant Goal #4: Consumer's voice is integrated into ADRC/SPE organizational governance** **Original Grant Goal #5: Person-centered planning and consumer direction are the basis for individual planning**				
Activities/Process	**Outputs**	**Measures**	**Outcomes**	**Outcome Measures**
The Consumer Advisory Board meets and makes recommendations.	Consumer Advisory Board Membership CAB attendance & meeting records CAB recommendations	# of members and consumer group they represent Attendance lists & minutes	Consumer Advisory Board input is valued and acted on.	Response to Consumer Advisory Board survey questions. Response to staff survey questions. Response to Governing Board survey questions.
Consumers are active members of MILTCC Governing Boards.	MILTCC Governing Board membership Staffing strategy to facilitate primary consumer participation.	# of primary and secondary consumer members on MILTCC Governing Board Attendance lists & minutes	The decisions of MILTCC Governing Boards reflect consumer input. Consumers feel that their participation on the Board is supported.	Response to Governing Board survey questions. Response to staff survey questions.
MILTCC staff are trained in Person Centered Planning.	Training	# of staff trained in PCP process	Trained staff understand PCP principles.	Response to staff training survey.
Person Centered Planning is practiced by MILTCC staff.	Case records	Specified below…	PCP approaches are used when assisting consumers.	Response to consumer survey questions. **Some type of observational method?**
MILTCC staff work with consumers to determine their needs.	Case records	Needs articulated & by whom	Consumers feel that their needs are understood.	Response to consumer survey questions.

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MILTCC staff work with consumers to determine their resources and assets.	Case records	Resources and assets articulated	Consumers feel that their resources and assets are understood.	Response to consumer survey questions.
MILTCC staff support self-determination. **What does 'support' mean?**	Case records	# of consumers who are interested in self determination and level of control preferred	Consumers feel that their goals for self-determination are understood and supported by MILTCC staff. Consumers are satisfied with their level of self determination and control in decision making and care management.	Response to consumer survey questions.
MILTCC staff identify the preferences of the consumer.	Case records	# of times Consumer preferences are articulated and recorded in consumer records	Consumers felt satisfied that their preferences were understood and supported. Consumers had what they need to accesses the services they preferred. Preferences that were frequently unmet were used to influence	Response to consumer survey questions.

			MILTCC planning.	
MILTCC staff provide consumers with options to consider that are appropriate to their needs and preferences.	Case records	# and type of options presented to consumers	Consumers received options to consider that fit their needs and preferences. Consumers had what they needed to access the services of their choice.	Response to consumer survey questions.
MILTCC staff act as consumer advocates.	Case records	# and type of advocacy provided to consumers	Consumers received the advocacy they needed to assist in accessing services. Creative solutions to meet consumers' needs and preferences were identified.	Response to consumer survey questions. Response to staff survey questions.
MILTCC staff facilitate future planning.	Case records	# of Consumers assisted with developing future plans.	Consumer feels future needs are understood and supported. Consumer is satisfied with the future planning they receive.	Response to consumer survey questions.
MILTCC staff maintain contact with the consumer through follow-up.	Case records	# and time frame of follow-ups	Consumer is satisfied with follow-up activity.	Response to consumer survey questions.

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The Michigan Long Term Care Connections Project strives for effectiveness in program implementation				
Activities/Process	**Outputs**	**Measures**	**Outcomes**	**Outcome Measures**
Staff are hired and trained in sufficient numbers to adequately serve consumers and their families.	Case records Staffing records Staff satisfaction	*Number of FTEs by job category* *#new contacts by job description at MILTCC* *#repeat or existing contact/clients by job description* Response to staff survey questions	Consumers are served within MILTCC timelines. Consumers feel they are served in a timely manner. Consumers do not feel rushed to make decisions.	# of consumers served within timeframes Response to consumer survey questions
Conduct time studies to determine amount of time needed for each function performed at MILTCC site.	Time study report	*# of minutes and hours per client for services*	Staff feel they have adequate time to serve the needs of consumers.	Response to staff survey questions
Study functional staffing models.	Models	*#hours in specialized activity* *# of staff in specialty function by specialization* *Use of specialty staff* *# of staff cross trained* *Use of cross-trained staff*	MILTCC sites have a plan for surge capacity. **What does this mean?** Consumers with special needs have access to specialty staff.	Response to staff survey questions

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A grievance process will be developed.	Grievance Procedures	# consumers utilizing grievance procedures	Consumers are satisfied with how their grievances are handled.	Response to consumer survey questions
MIS workgroup will be convened. Servicepoint will be developed and modified to track callers, consumers and resources, and produce data reports. Staff will be trained in entering data in Servicepoint. Remote data input capability will be developed for staff offline.	List of fields needed for data management and reporting in Servicepoint Training Fields needed for remote data entry	Inclusion of fields in software Training attendance Fields and forms for uploading	Servicepoint contains the necessary fields. Staff understand how to use Servicepoint. Data are recorded and reported accurately. Information technology supports MILTCC sites' business model for consumer tracking. **What does this mean?**	Accuracy of data reports Response to staff survey questions
Data software (Servicepoint) will be used to manage consumer information	Case records Resource database	Level of missing data Data quality	Staff consider Servicepoint data reliable and valid. Staff report satisfaction with Servicepoint.	Response to staff survey questions
A Continuous Quality Improvement process will be developed to track challenges and success. MILTCC staff will review QA protocols and procedures regularly.	CQI plan QA protocols and procedures CQI measures	Reporting on CQI measures	MILTCC sites use data from CQI process to make improvements.	Response to staff survey questions Response to board survey questions

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CQI measures will be developed and implemented. MILTCC will share QA information with governance and stakeholders.				
A strategy to track the LTC costs by individual will be developed and implemented.	Report describing strategy	To be defined	The costs of various care options can be compared.	To be determined
The long term care system will assess its effectiveness in serving consumers.	Evaluation	# of people served through MILTCC Evaluation results	Consumers felt the process was an effective means of meeting their priority needs. Consumers received what they needed to use public and private funds to access services. Consumers feel MILTCC has had a positive impact on their lives. Consumers feel they can actively participate in their LTC planning.	Response to consumer survey questions

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The Michigan Long Term Care Connections System seeks to improve system capacity through evaluation of system change and consumer success in accessing services.				
Activities/Process	**Outputs**	**Measures**	**Outcomes**	**Outcome Measures**
The capacity of the LTC system to meet consumer needs and preferences will be determined.	Needs assessment reports Unmet needs and preferences documented in case records Unmet needs and preferences documented in evaluation	Unmet needs and preferences identified by consumers, staff, and partners Reasons for unmet needs and preferences	LTC system uses information collected to adjust and adapt to meet consumer needs and preferences.	Response to staff survey questions Response to partner survey questions Case records **Measure of use of home and community based services?**
The capacity of the LTC system to meet consumer needs and preferences will improve over time.	Unmet needs and preferences documented in case records Unmet needs and preferences documented in evaluation	Unmet needs and preferences identified by consumers, staff, and partners Reasons for unmet needs and preferences	Unmet needs and preferences decrease. More consumers are able to access LTC services that meet their goals, fit with their preferences, and reflect their values. More consumers utilize home and community based services to live in the residence of their choice.	Response to staff survey questions Response to partner survey questions Case records Medicaid records Nursing home occupancy rates **We need to identify data sources for several of these outcomes.**

Items in italics refer to ADRC-MDS/SART Data Elements

			Individuals residing in nursing care facilities will display increased acuity. The rate of nursing home occupancy by individuals over the age of 65 will decrease. The number of individuals wishing to leave institutional settings who are able to do so will increase. The proportion of individuals discharged from post acute hospital stays to the community will increase. LTC Medicaid costs per consumer decrease.	
Stakeholder groups will receive information about evaluation results.	Reports Presentations	# of presentations of evaluation results # reports disseminated Audiences reached	LTC system uses evaluation results to inform decisions.	Response to staff survey questions Response to partner survey questions

Long Term Care Connections Logic Model Action Plan (Draft March 19, 2007)

The goal of the project is to establish ADRCs to serve as a comprehensive resource on long term care and provide information and assistance in accessing services, planning for long term care financing and delivery, benefits outreach and proactive choice counseling for the general population.

Items in italics refer to ADRC-MDS/SART Data Elements

Goal 1: Improved Access to LTC Support Services: Development of a One-Stop System		
Objective 1: Provide awareness, information and assistance		
Strategies/Major Action Steps	**Outputs**	**Outcomes**
Awareness: Strategy 1. Develop and implement a marketing and outreach campaign for people of all financial circumstances • Inclusive stakeholder process involving consumers, families, friends, targeted audiences. Look at age, race, payers, and providers. • Develop single logo Year 1 • Identify target audiences, develop messages, Year 2 through 4 • Seek promising practices for outreach and marketing Year 2 • Target marketing and outreach to hospital discharge planners and providers. Year 1 • Identify regional partners to assist in developing cultural competent materials Year 2 • Outreach program to legislators Year 3 • Explore marketing campaign for LTC financial planning. Year 2 • Expand marketing LTC financial planning to state wide audience • Develop plan for sustainability. Ongoing • Develop a public information and awareness campaign template Year 3 (State to develop marketing package to be used across the state.) • Conduct statewide campaign to targeted audiences year 4 and 5.	Single Logo Presentations Media releases, etc Marketing plan. Culturally competent materials. Campaign template LTC financial planning campaign options Sustainability plan	Consumers and families receive a clear, consistent, culturally competent, useful response, materials, and messages from SPEs across the state. Short and long-term goal. People understand where to go when they need information on LTC supports and services. Long-term goal. Outreach campaign reaches people in economically and culturally diverse populations Mid-term goal Consumers, families and providers receive information that is unbiased, reliable, comprehensive and useful. Consumers, families, and providers are more knowledgeable about and more likely to practice PCP.

Information: Strategy 2. Develop a comprehensive resource database for LTC supports and services. • SPEs populate ServicePoint as data base for LTC services and resource. Year 1 and to statewide year 3 and 4 • Establish access and customize CommunityPoint for public use. Year 2 • Explore collaboration with 211 networks. Year 2 and 3 • Develop a plan (with collaboration with 211 if available) to maintain the database • Year 3 and 4 e: expand access and information on data base for statewide use	Comprehensive database	Public has 24/7 access to a statewide database Year 2
Information: Strategy 3 Develop links to experts in the field that can provide specialized information. Year 1 and 2 • Identify organizations with expertise. MOUs with expert organizations. (Ombudsman, Alzheimers Assn.) Expand state wide year 3 and 4	Signed MOUs	_____ Consumers, families, and providers received to specialized information in a timely way.
Assistance Strategy 4 Implement policy that provides assessment, level of care determinations and options counseling through a network of single point of entry entities. • Evaluate SPE performance on consumer satisfaction and cost effectiveness Year 2 and 3 • Develop policy requirements for mandatory LOC screening for all Medicaid eligiblies through the SPE network year 1 and 2 • Expand SPE service network for state wide year 4 and 5	Consumer is made aware of the benefits and risks of their choices.	Statewide access to SPE services
Assistance Strategy 5 Convene stakeholder group to develop a model and implementation plan to establish an independent advocate. Year 2 • Independent advocate options include consumers and peers. • Consumer input to plan be fully considered • Plans with multiple approaches to Independent advocate use multiple agency input.	Design and implementation recommendations	Implementation plan.

Objective 2: Streamline multiple eligibility processes.		
Strategy 1. Establish an interagency access project team to streamline financial and functional eligibility and assessment processes Year 1 through 3 • Explore best practices. • Explore possible policy changes across agencies. • Early state stakeholder involvement. • Prioritize systems changes needed for electronic Medicaid financial application. Ensure compatibility with new DHS and DCH computer systems. • LOC Determination electronic system must be changed to accommodate SPE demos. Strategy 2. Develop a functional assessment and planning process that incorporates person-centered planning, is comprehensive, modular and meets multiple consumer, provider and state needs. (Year 1 through 3) • Identify existing information collected among long term care programs • Identify and define core elements that will be assessed • Identify and develop modular component assessments • Develop and test the instrument • Provide guidance and training to SPE staff • Identify systemic barriers to change • Define SPE responsibilities for eligibility assessment and planning. • Seek broad stakeholder buy-in. • Explore, make available and promote consumer self assessment and planning opportunities including benefits check-up. • Expand use of modular assessment state wide year 4 and 5	Universal, modular, functional, evaluation process across settings and programs. SPE policies and procedures established. Define steps in PCP process. (Addressed by Group 2.)	Consumer characteristics can be compared across publicly-funded LTC services and supports in a uniform way. A simplified eligibility determination process is used across funding streams and programs. • Consumer does not have to retell their story. • Consumer receives determination in an efficient, timely manner. • Consumer's retain control of their personal information within the context of PCP.
Strategy 3 Develop and implement policies that support early assessment and options planning with individuals whose course of care will likely include nursing facility services • Compile information about other states policies and legislation mandating LOC screening and options planning for the non-Medicaid population • Develop data models that can assess asset depletion for Medicare and private pay individuals to predict candidates for early assessment. • Expand state wide year 3 and 4	Screening and options planning policies.	Fewer individuals experience unnecessary institutionalization or prolonged institutionalization doe to failures in planning.

Strategy 4. Develop a mechanism for sharing information among providers • Maintain privacy of consumer information (compliant with HIPAA) • Share information in individual's PCP with appropriate, involved providers. • Explore and analyze strategies and technologies available to share consumer information • Include consumer- completed or driven self-assessments. • Develop plan to evaluate usefulness of web based ChoiceNet portal. • Expand state wide year 3 and 4	Design for information-sharing mechanism Evaluation plan and report	Demonstrated administrative efficiencies Greater consumer and provider satisfaction with information sharing procedures
Objective 3: Target individuals who are at imminent risk for admission to an institution.		
Strategy 1: Develop capability to provide short-term critical intervention to stabilize situations for individuals at imminent risk of nursing facility placement. • Explore best practices from other states. • Explore better collaborations with other organizations for example APS, facility closure teams. SPE identifies data elements to document gaps in service related to short term stabilization. SPE regional needs planning standards include direction for identification and service planning related to gaps in short term crisis services • Expand state wide year 3 and 4	Policies and procedures for short-term critical interventions.	Communities have improved capacity to provide affordable, immediate, short-term interventions.
Strategy 2: Develop a targeting methodology and implement an information and assistance strategy for individuals pending hospital discharge. • Identify characteristics of hospitalized persons likely to need LTC services. • Identify specific ways for consumers to work closely with staff to explore a variety of care options. • Partner with the Michigan QIO and accreditation organizations. • Implement PA 634 requiring person seeking Medicaid funding of LTC services go through a SPE. • Develop MOUs between hospitals and SPEs to match consumers with options counselors. • Expand state wide year 3 and 4	Targeting methodology specified Signed MOUs	

Strategy 3: Develop a targeting methodology and implement an information and assistance strategy for identifying individuals in the community who are at risk for unwanted, avoidable institutionalization. • Define institutionalization (what does CMS mean by this?) • Inform individuals of all options and choices. • Identify characteristics of individuals in the community likely to need LTC services. • Educate volunteers and service organization staff to identify individuals in target population; establish partnerships and feedback loop. • Identification of key resources that prevent placement in unwanted residential settings. • Expand state wide year 3 and 4	Targeting methodology specified	Through person-centered planning people (including those in targeted populations) have the information and support they need to make informed choices of their options (including benefits and risks). Consumers live in the settings of their choice.
Strategy 4: Identify individuals in nursing facilities with high potential for transition. • Conduct transitions based on individual responses to the MDS. • Self-referrals to SPEs. • Conduct NHT transitions statewide once statewide SPEs are implemented. • Develop policies and best practice guidelines for nursing homes. • Finalize policies and best practice guidelines for waiver agents. • Develop template MOUs for nursing home transitions for nursing homes and SPEs. • Expand state wide year 3 and 4	Statewide NHT policies and procedures Signed MOUs	Individuals who choose to living in the community transition from nursing facilities

Goal 2. Increased choice and control: develop and enhance self-directed service delivery system		
Objective 1: Develop person-centered planning		
Strategies/Major Action Steps	**Outputs**	**Outcomes**
Strategy 1: *Develop state-level practice guidelines*: a. Identify work group of consumers, advocates and other stakeholders to develop PcP practice guidelines (better define stakeholders…..majority of stakeholders need to be consumers & advocates, but also providers (direct care workers), physicians, other medical model types, state staff) driven by consumers & advocates b. Research existing materials (within the state and nation) on PcP c. Report to work group on findings d. Develop outline for practice guidelines including establishing core principles e. Determine if practice guidelines conflict with existing rules and regulations f. Establish minimum standards and performance indicators directly related to PcP g. Create glossary of PcP definitions and essential principles across all long-term care and disability populations h. Identify entities to which the practice guidelines apply i. Draft state-level practice guidelines for broad-based review using person focused/user friendly language j. Revise practice guidelines based on feed-back from broad-based review k. Re-disseminate practice guidelines for second review and comment l. Revise practices based on second-round feedback m. Promulgate practice guidelines n. Develop a roll-out strategy for the practice guidelines	Products to be produced: a. Written description of minimum standards and performance indicators b. Summary report on the MI history of PCP development c. Glossary of definitions and essential/guiding principals d. List of applicable/participating entities e. Draft PCP practice guidelines f. Roll-out plan description g. Draft contract language criteria h. Develop data collection forms or audit protocols i. Develop risk management policy and guidelines	LTC system operates under consistent PCP practice guidelines Program participants are offered more flexibility, choice and control within the service delivery system Participants receive services and supports they choose and desire Participants have choice of supports Participants have choice of service delivery options, i.e., traditional, self directed, hybrid The principles of PCP apply to every aspect of program operations including: 1) individuals identify their goals, needs and preferences; 2) developing and managing the plan to meet goals, needs and preferences; 3) identifying and managing risks; 4) planning for emergencies (contingency planning/back up); 5) developing the individual budgeting development; and 6) monitoring strategies Each participant is provided information

o. Distribute practice guidelines according to roll-out strategy p. Identify resources for sustainability of practice guidelines are q. Promulgate PcP Policy, extend/expand this idea r. Will reflect cultural sensitivity s. Build a support system of community and allies to support the person as the individual prefers (Does the person have or has the system built *Strategy 2: Develop site review criteria for application of person-centered practice guidelines:* a. Identify member and establish work group to develop review criteria b. Perform assessment of existing criteria (state and national) c. Present findings to work group d. Draft review criteria e. Evaluate and field test criteria f. Modify review criteria based on testing and evaluation h. Identify resources and personnel to train, perform and enforce the reviews i. Modify provider agreements/contracts to impose the application of practice guidelines as a condition of participation j. Perform monitoring reviews k. Develop system to report, collect, aggregate and analyze site review findings l. Share findings with appropriate stakeholders and the Quality Management System m. Evaluate the process and outcomes through participant and provider feedback n. will reflect cultural sensitivity o. individual budget reflects changes in individual circumstance and need for change in PCP	Products to be produced: a. Draft site review criteria b. Evaluation tool c. Training materials	regarding rights, risks, and responsibilities Build a support system of community and allies to support the person as the individual prefers (Does the person have or has the system built _____ (#) training sessions are performed At least ____% of sites are compliant with the review criteria

Strategy 3: Ensure that the State operates under a PCP process in all facets of the waiver operation. a. Apply the principals of PCP to: 1) individual identifies goals, needs and preferences; 2) developing and managing the plan to meet goals, needs and preferences; 3) managing risks; 4) planning for emergencies (contingency planning/back up); 5) developing the individual budget; and 6) apply monitoring strategies through the creation of: • Definitions for above six domains • Policy to implement the six domains • Monitoring system to ensure the application of the policy	Policy and monitoring system	Consistent implementation of person-centered plannning
Strategy 4: Develop and implement multiple layers of training on person-centered planning to accomplish the shift in attitudes and practices necessary for a person-centered approach throughout the LTC system a. Identify work group of consumers, advocates and other stakeholders to develop training process b. Identify and evaluate current PCP training, what works well, what doesn't work well – c. Determine core principles and areas that are diverse d. Assess levels of understanding of PCP by community/population e. Share information/findings with work group f. Identify resources to create and sustain training initiative g. Develop training curriculum using: • Independent facilitation • Participant experiences/stories h. Develop peer mentoring for PCP i. Identify training methods (written manuals, web-based, CD, physical attendance, others) j. Identify training needs – who and what k. Develop PCP training as a process and philosophical thinking l. Evaluate training and techniques m. Ensure ongoing consumers/advocates/stakeholders drive the reviews of these training activities n. Develop PCP training for practitioners	Products to be produced: Training curricula is developed considering various levels and types of providers/individuals, and is population specific: a. Document findings of current MI training assessment b. Develop research report on other state's tools/training efforts c. Develop training curricula tool kit (videos, talking books, written material, CD, web-based, etc.) d. Create an training evaluation form e. Develop PCP promising practices reports	Training is provided to all levels of providers/individuals Integration of core practices are applied by providers across the LTC system Attitude and practices of organizations and personnel shifts to honor consumer choice and control Participation in training increases knowledge, utilization and effective use and practice of PCP. (Participant satisfaction & expert observation and evaluation) LTC providers report an increased understanding of the principles, processes & thinking of PCP through education and training

Strategy 5: Evaluate the implementation of person-centered planning to determine if goals of improving participant quality of life and system reform are achieved for individuals. a. Develop participant surveys to obtain participant feedback on the PcP process and the quality of the LTC service delivery system b. Identify work group of consumers, advocates and other stakeholders to research, draft and evaluate the survey c. Research existing surveys (state and national) d. Report to work group on findings e. Identify core elements of surveys and population/community specific elements e. Develop draft participant survey f. Field test survey g. Modify survey as needed h. Conduct broad-based participant surveys i. Collect data on findings, analyze and publish results *Strategy 6: Evaluate the implementation of PCP to determine if goals for system reform are achieved system-wide.* a. Identify quantifiable measures b. Identify outcome measurements in QM plan c. Identify and reduce resource barriers that limit choice and control d. Develop an effective and realistic strategy to measure outcomes	Products to be produced: Participant Survey Quantifiable measures Data collection tools - Annual Quality Reports to include analyses, outcome measures, longitudinal data and enchmarks for implemetnation.	All individuals receiving LTC State services are given the opportunity to participate in PcP Participants who participate in PCP demonstrate good or improved quality of life. Participants express satisfaction with LTC services How many people have budgets, # participated in PCP?

Objective 2: Develop individual budgeting		
Strategy 1: Develop state level guidance on the development and implementation of individual budgets a. Create an individual budget stakeholder work group that will work on developing the guidance & budget guidelines, formula process b. Develop a model tool or formula that provides for a fair distribution of resources for all participants in all areas of the state based on the simplistic PCP principals c. Research methodologies if developing an individual budget and present to work group d. Draft individual budget process and ensure it is evidence-based and is consistently applied, no two individuals have the same needs, all individuals get what they need and want e. Create a prototype for managing the individual budget electronically f. Revise policy and practices based on feed-back from broad-based review g. Re-disseminate policy and practices for second review and comment h. Revise policy and practices based on feedback i. Pilot individual budget process, train participating staff/participants and evaluate results – modify process as needed j. Pilot the electronic management of the individual budget k. Develop an individual budget roll-out plan of the policy and practices to include statewide training l. Evaluate the individual budget process (including the electronic application) annually through participant surveys and other feed-back methods m. Identify resources by which to support individual budget process, training, evaluation and sustainability n. Obtain participant feedback on individual budget process o. Develop the means by which individuals have the ability to track balance of individual budget	Products to be produced: Individual budget process is articulated in written policies and procedures Data collection forms and reports Published cost reports Training tools	Participants have increased choice and control over their individual budgets. State level guidance on budget development is consistently applied throughout the LTC system. core criteria for what must be contained in every budget and is consistently applied. The budgets reflect what is specified in the PCP. Does the budget reflect what is contained in the plan? Budget neutrality is maintained in the aggregate.

Strategy 2: Develop and implement state level training and technical assistance on budget development to increase understanding of individual budgeting and how it supports the goals of system transformation. a. Use the individual budgeting work group to develop training and technical assistance strategies b. Identify and/or develop training tools and resources c. Draft pilot training curricula for the individual budget process including electronically monitoring d. Use experiences/stories as examples of PCP as training tools e. Identify resources to conduct and support training activities to ensure sustainability f. Identify a continuous monitoring and reporting process to oversee the quality of the individual budgeting system g. Perform site reviews to determine if participants are informed of the methodology used to calculate and manage their individual budget h. Investigate training methodologies? Manual? Web-based? CD? Physical Attendance? All? i. Identify training needs – who and what j. Evaluate training and techniques k. Modify training approach as needed based on the evaluation l. Ensure consumers/advocates drive the reviews of these activities	Products to be produced: a. Assessment/evaluation of training is developed b. Training attendance records are captured c. Reports on monthly budget balances are captured d. Reports on utilization are developed e. Reports on over and under spending tracking f. Participant survey is modified to obtain feedback how is it going… are you satisfied with you budget, is it working for you? g. Individual budget that is considered across all funding sources, other Medicaid fund streams h. State develops curriculum that is used to train the system.	Participants understanding how their budgets are developed The LTC system providers have an understanding of the individualized budget process On-going training on the individual budget system process is available to participants and providers LTC providers and participants have access to technical assistance and training Participants have adequate support to manage their budget Participants report satisfaction with the level of training and technical assistance that is available Participants are in control over their budgets and know balances

Objective 3: Develop participant-employer options		
Strategy 1: Develop state level guidance on the Choice Voucher System and Agency with Choice models for direct employment of workers to facilitate successful participant direction. (Separate CVS from AWC and use same action steps for both) a. Identify employer options work group composed of consumer, advocates and other stakeholders b. Research available employer options nationally (other options that we find or conceive of them) c. Report findings to work group d. Determine which employer options are appropriate for consideration in MI e. Develop a plan to create the infrastructure/providers to support the various options f. Amend existing waivers to include the new employer options g. Create new policies/protocols to mange the new options h. Develop a roll-out plan to provide consumers information on the new approaches i. Develop monitoring strategies to over-see the operations j. Provide training and information to participants and providers to support informed choices of employer options k. Develop a means by which to evaluate new employer option providers (participant survey) to ensure choice and control	Products to be produced: Training curriculum Information brochures Evaluation forms Evaluation Reports Report summaries are shared with collaborators	Participants are provided options to mange their employees Supports are available to assist participants to manage their staff

Strategy 2: Develop and disseminate state level policy guidance on Fiscal Intermediaries as employer agents for participants directly employing workers. (employer agents) a. Continue using the employer options work group composed of consumer, advocates and other stakeholders to develop the Fiscal Intermediaries provider community (FIs) b. Research available FI options nationally c. Report findings to work group d. Determine which FI options are appropriate for consideration in MI e. Develop a plan to create the infrastructure/providers to support the FI model(s) f. Amend existing waivers to include the new FI options g. Create new policies/protocols to mange the new options h. Develop a roll-out plan to provide consumers information on the new approaches i. Perform readiness reviews on selected new providers j. Develop monitoring strategies to over-see the operations of the FI k. Provide training and information to participants and providers to support informed choices of employer options (choices) and serve as the common-law employer l. Develop a means by which to evaluate FI option providers (participant survey)		People have choice of FI & choice of options That participants understand the role of FI What types of entities should be FIs, co-ops?

Strategy 3: Develop training and informational materials for participants, their allies and advocates to increase understanding of the value of and methods for directly employing workers. Marketing and training materials a. Use the employer option work group to develop training and technical assistance strategies for individuals directly employing workers b. Identify and/or develop training tools and resources to aid participants to recruit, interview, select manage and dismiss employees c. Draft pilot training curricula for the individuals servicing as the employer d. Use experiences/stories as examples in training e. Identify resources to conduct and support training activities to ensure sustainability f. Ensure the FI operates under PcP principles g. Investigate training methodologies? Manual? Web-based? CD? Physical Attendance? All? h. Identify training needs – who and what i. Evaluate training and techniques j. Modify training approach as needed based on the evaluation k. Ensure consumers/advocates drive the reviews of these activities		Participants have increased understanding of the value of and employing workers. Persons are aware of their role in managing and the value of employing workers directly Information is user friendly, culturally competent and readily available Consumers PCP include established backup and emergency plans and risk management strategies.

Objective 4: Ensure self-directed supports		
Strategy 1: Provide training and informational materials on supporting successful participant direction that address misperceptions on liability issues and describe methods for supporting participants. a. Identify members of a self-directed support work group composed of consumers, advocates and other stakeholders b. Research existing materials and tools to support individuals self-directing including areas of the FI, supports brokerage and independent advocacy options c. Identify and/or develop training tools and resources to develop and manage supports d. Research and identify strategies other states have used to reduce consumer liability e. Report to work group on the findings of research f. Draft pilot training curricula for the individuals self-directing using experiences/stories as examples g. Ensure focus of the supports and training include management of the budget, selection of service options, risk management, and contingency planning h. Identify resources to conduct and support training activities to ensure sustainability i. Investigate training methodologies? Manual? Web-based? CD? Physical Attendance? All? j. Identify training needs – who and what k. Evaluate training and techniques l. Modify training approach as needed based on the evaluation m. Ensure consumers/advocates drive the reviews of these activities	Products to be produced: Information pamphlets Training materials Who to contact specialties (magnets) Evaluation of trainings by participants	The number of Agency with Choice providers increase Independent Supports Broker positions increase

Strategy 2: Make State level policy changes that will support and remove barriers to participant direction. a. Identify work group to research and issue recommendations on State laws and policy to enable the promotion of self-direction including the Deficit Reduction Act b. Research regulations and state laws to identify barriers c. Research other State self-directed programs and recommend modifications to the work group c. Develop strategies to eliminate barriers d. Draft and submit language changes to appropriate officials e. Promulgate changes f. Develop a roll-out plan to inform communities of the changes g. Determine what additional training/resources should be developed h. Train appropriate individuals on new policy/laws i. Evaluate the impact of the changes j. Obtain consumer input on changes.	Analysis of existing policy Policy Bulletins Policy Promulgation steps Training on new policy changes	Policy is modified Participants report improved satisfaction with access and services
Strategy 3: Provide state level guidance on supporting participant direction and how to address barriers. a. Using the supports work group, examine other State approaches to developing en managing the support necessary to ensure the success of self direction b. Report findings to the group for discussion c. Draft plan to develop and implement supports for self direction including job description, minimum qualifications, training curricula and continuous monitoring strategies d. Ensure consumers have a role in developing the responsibilities and activities and evaluating the effectiveness of supports brokers and other supports c. Foster local mentors by creating a peer support system including training d. Evaluate the effectiveness of peer supports	Products to be produced: Convene taskforce, including consumers and providers, to identify barriers and identify plans for addressing those barriers. Job description P&P Training Reports on # of support coordinator independent support brokers Compare ratios	Barriers are identified and addressed

Goal 3: Create a system that more effectively manages the funding for long-term supports that promote community living options		
Objectives 1: Develop and implement a mechanism allowing flexible spending within the LTC budget consistent with consumer needs and preferences (may need to check with CMS)		
Strategies/Major Action Steps	***Outputs***	***Outcomes***
Strategy 1. Develop analysis, planning and forecasting capacity that supports annual policy development, planning and budgeting for long-term supports • Use the analysis to develop a model to use to study results to forecast and develop an annual budget • Develop data analysis agenda • Identify data sources • Develop data reports • Build data reports and forecasts into annual long-term supports planning • Develop "what if" scenarios to project alternative trend lines and develop a shared interpretation of the merits of these scenarios • Develop liaison with legislative fiscal agencies and budget office • Identify and conduct special studies to identify key predictors of successful community support for SPE consumers who are assessed at the NF level of care	• Forecasting is improved • Ongoing budget management and tracking process • Data is obtained that predicts the number of consumers and services needed • Written reports are prepared • Written high, moderate and low scenarios are prepared • Stakeholders share a unified message on long term care policy (switch with regular) • Executive and legislative budget people are on the same page shared preferences, awareness of shared missions • Studies completed	More Medicaid consumers are served with the appropriation over time. Funding is flexible enough to support consumer choice. • Regular meetings are held to exchange information between legislative, budget and policy staff (switch with stakeholder) • Stakeholders have access to financial information and participate in the development of a unified message on LTC Consumers have access to a full array of settings and services of their choice
Strategy 2. Establish a unified state budget appropriation line for long-term supports which is flexible and meets changing needs.		

• Research methods used by states with single line items to manage their appropriation • Determine needs, costs and available resources, associated with nursing facility transition and single point of entry referrals to long-term care programs • Involve budget office staff and key legislative staff in periodic briefings of data analysis and trends lines	• Identify and interview states with a unified budget • Report on state budget processes • A legislative champion for a unified budget will be identified • The budget methodology will follow money follows the person concepts & principles • A unified budget line will be created • Mechanisms to manage the appropriation including the risk of overspending will be established • Spending will be monitored regularly and policy/budget options will be prepared if the spending trends exceeds the appropriation • Key decision makers will be informed about long term care policy • Regular conferences/ meetings will be held with legislative staff	• A report is prepared and dessiminated • Spending trend lines are tracked by setting (institutional, residential and in-home), acuity, populations, demographics, etc. The unified budget supports a long-term care system based on the money follows the person principles. Based on improved forecasting, the budget more appropriately reflects consumer needs for long term care services. • Policy adjustments that may be needed to remain within the appropriation are selected
Objective 2: Develop and implement more effective payment methodologies		
Strategy 1. Develop risk adjusted payment models for all long-term care programs • Obtain information about case mix payment systems in other states • Complete pilot tests and budget analysis of the payment method	• States with experience with case mix payment systems will be identified and interviewed • A report on state case mix practices will be prepared • Models based on state practices will be developed	• Risk adjusted payment system are selected. • Payment rates are based on elements from the functional assessment, and include “cost bands” with an exception process

• Conduct a study of Home Help Program (state plan personal care) individuals eligible for nursing facility level of care • Examine options for including high-needs state plan personal care into a risk adjusted model for agency provider payments • Develop and implement Medicaid policy that assures that the assessment produces a risk adjusted payment for all SPE Medicaid eligible consumers for all programs	• A study of Home Help participants will be completed • Providers will have incentives to serve individuals at all levels of need consistent with consumer choice • RUGS-like, or other case-mix payment methodology will be developed	Consumers, across acuity levels, have the financial support they need to receive services consistent with their needs and choices. Consumers with higher needs have the financial support they need to access to an array of service providers.
Strategy 2. Using a single integrated assessment instrument, addressed under Goal 1, develop and implement a model that assigns risk adjusted payment rates that apply to all long-term care options • Review other states experience on developing and implementing risk adjusted payment methodology • Define the elements from assessment tool that contribute to a risk adjusted payment methodology • Develop methodology to weight elements • Identify contractor to develop case mix methodology • Develop methodology to transition facilities to new rate system	• Examine risk adjusted payment methodology in other states that are linked to the assessment tool– Oregon and Washington model • Prepare report on state models • Develop separate reimbursement models for nursing home, residential & community settings, and managed care organizations • Develop payment methodologies for each setting e.g., MIChoice with ability for adjustments, as necessary • Plan to phase in the methodology for other settings	• Models are designed • Amodel and an implementation plan and are designed • A plan is developed

Strategy 3. Develop approaches that support implementation of pilot(s) pre-paid health plan models for long-term care • Form a work group to study development of pre-paid long-term care health options • Obtain information and analyze other states' approaches to prepaid long-term care health plan models to inform workgroup. • Develop and submit a Request for Proposal • Implement prepaid long-term health plan pilots • Coordinate and transition pilots from MFP grant. • Using data and outcomes from the MFP pilots, review and modify policy principles to provide a base for development of statewide prepaid long-term care health plan options of MFP and person centered planning principles	• A work group on pre-paid health plans will be formed; regular meetings will be held • Integrated care models used in other states will be reviewed • A report on care models in other states will be presented to the work group • Prepaid long term health plan pilots • Activities from other states, will be compiled and available to stakeholders through a web based process • The adequacy of provider network will be evaluated to determine whether it will meet needs of enrollees and provide access to an array services • Obtain acuity and utilization data • Customer satisfaction surveys • A plan for statewide implementation	• Stakeholders receive information and participate in the development of the plan • Report on models in other states • Entities are selected and receive contracts • The contractors manage long term care funding Contractors have provider networks that meet consumer needs. Network providers embrace PCP. Participants have improved outcomes Customer satisfaction with the Long Term Care funding system is high. • An implementation plan is prepared .

SYSTEMS TRANSFORMATION GRANT
STRATEGIC PLANNING
March 2007

LONG-TERM CARE WEB SITES

The following web sites contain background materials relevant to the grant planning:

Office of Long-Term Care Supports and Services web site
http://www.michigan.gov/ltc
At this site, you will find links to a wide range of LTC information, including:

- The Long-Term Care Task Force final report
- Consumer Task Force web site
- LTC Connections (Single Point of Entry) web site

Public Act 634 of 2006, Single Points of Entry
http://www.legislature.mi.gov/documents/2005-2006/publicact/pdf/2006-PA-0634.pdf

Centers for Medicare and Medicaid Services, New Freedom Initiative
http://www.cms.hhs.gov/NewFreedomInitiative/

CMS System Transformation Grants
http://www.cms.hhs.gov/RealChoice/downloads/FY2006RCSCsolicitation.pdf

Deficit Reduction Act/Money Follows the Person Demonstration Grants
http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp

Promising Practices in Home and Community-Based Services
http://www.cms.hhs.gov/PromisingPractices/01_Overview.asp

ADRC Interim Report for Centers for Medicare and Medicaid Services
http://hcbs.org/files/101/5022/ADRC_Interim_Report_-_Ex_Summary.doc

A Guide to Quality in Consumer Directed Services
http://hcbs.org/moreInfo.php/topic/202/doc/819/A_Guide_to_Quality_in_Consumer_Directed_Services

The ABCs of Nursing Home Transition
http://hcbs.org/moreInfo.php/topic/207/ofs/10/doc/1722/ABC's_of_Nursing_Home_Transition

Beyond Cash and Counseling: An Inventory of Individual Budget-Based Community Long-Term Care Programs for the Elderly
http://hcbs.org/moreInfo.php/topic/221/ofs/10/doc/1568/Beyond_Cash_and_Counseling:_An_Inventory_of_Indivi

If you are unable to link to a site, or need a paper copy, please contact Jackie Tichnell at tichnellj@michigan.gov or 517-335-7803.

Person-Centered Planning
for Community Based Long-Term Care

Practice Guideline
Review Draft March 2007

"Person-Centered Planning is a process for planning with and supporting the individual receiving services. The process builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices and abilities."

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Person-Centered Planning for Community Based Long-Term Care
Practice Guideline
March 2007

"Person-Centered Planning is a process for planning with and supporting the individual receiving services. The process builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices and abilities."

I. Purpose

This document provides guidance and technical assistance on how to successfully implement the Person-Centered Planning process with individuals participating in the MI Choice Medicaid waiver program and other community based long-term care services. The Person-Centered Planning process is a contract requirement for MI Choice waiver agents, which provide community-based long-term care services to people who are aging or have disabilities.

The Michigan Department of Community Health, Office of Long-Term Care Supports and Services has convened a discovery and training process for MI Choice waiver agents and the long-term care community as a whole to identify exemplary practices in Person-Centered Planning. This policy and practice guideline is an outcome of that process.

The Person-Centered Planning process ensures that individuals who need long-term care supports and services have a method for identifying their goals and preferences and the necessary supports and services. The process enables individuals to maintain their lives in the community, increase or maintain their quality of life, and address health and welfare issues.

In the Person-Centered Planning process;

- Individuals know their options,
- Individuals make their own decisions,
- Individual decisions are driven by their life goals and priorities,
- Individuals have the support of allies in planning, developing and implementing their supports and services.

2 II. Person-Centered Planning Process (PCP) Definition

Person-Centered Planning is a method used to assist individuals in planning for how they wish to obtain the supports and services they need and want within the context of how they live their lives at home in their communities. The individual directs the planning process with a focus on what he or she wants and needs.

PCP is individualized, designed to respond to the desires and preferences expressed by the individual. As a process for planning and supporting the individual, it builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices and abilities. The process also can quickly adapt to changing needs and desires.

Often, individuals select allies to become involved in the Person-Centered Planning process; these allies may include family, friends, professionals, or caregiver staff. The involvement of allies is the choice of the individual; some people will choose not to involve any of their allies or will invite only one or two people to participate. Professionals, who have traditionally been involved in the planning and delivery of services, may have a role in the Person-Centered Planning process and their recommendations and assessments may be used in the planning process. The supports coordinator must be involved because he or she is responsible for authorizing the service plan. However, the development of the service plan, including the identification of possible supports and services and providers, is based on the expressed needs and desires of the individual rather than the recommendations of the professionals. The individual's choices drive an ongoing process of setting goals (such as where they want to live, how they want to connect with others, the activities in which they want to participate) making plans, selecting supports and services, evaluating progress and outcomes, and revising or setting new goals. The goals and identified supports and services are incorporated into a service plan that includes both paid supports and services (such as MI Choice waiver services) and unpaid support (such as support provided by a spouse) that shapes service delivery implementation and is revised as needed.

3 III. Background

4.1 A. Shifting to a Person-Centered Model

The role of long-term care services is to assist individuals in meeting their health and welfare needs. Historically, long-term care service delivery has been based on the medical model, which focused on treating the health condition of concern. Medical professionals made decisions about treatment and service settings. The setting for long-term care was typically the nursing home. Federal regulations favored this approach. Recently, other community alternatives became more available.

4.1 B. History of Person-Centered Planning in Michigan

The movement toward person-centered planning has been growing in Michigan for the past two decades. Originally, person-centered planning was developed as a method for working with persons with developmental disabilities to identify their dreams, goals and preferences.

As the concept was introduced in Michigan in the late 1980s and early 1990s, the independent living philosophy was incorporated into the Person-Centered Planning process so that the individual could use the planning process to develop the life he or she chooses in the community with work, meaningful activities, friends and relationships and other means of community involvement, just like everyone else. In 1996, legislation was passed that required individuals receiving supports and services in the public mental health system to develop an individual plan of services using a Person-Centered Planning process. In the last ten years, individuals with developmental disabilities and/or mental illness have used this process to pursue their goals to live, work and be involved in the community with the support they need and want.

4.1 C. Person-Centered Planning in Long-Term Care

The philosophy of Person-Centered Planning has been embraced statewide as the method for individuals who need long-term care to plan for supports and services to enable them to maintain their lives in their homes, neighborhoods and community and to maintain or obtain connections with other community members. The Michigan Medicaid Long-Term Care Taskforce was appointed by Governor Granholm in 2004 to: "examine and report on the current quality of Medicaid long-term care services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan." The final Taskforce report identified Person-Centered Planning as a central policy recommendation. It recommended:

"Use Person-Centered processes and tools to assess and match the individual's needs and desires across a continuum of LTC services based on demonstrated need, effective individualized management and care planning."

In addition, its seven other recommendations focused on individual choice and control by making available: a continuum of long-term care options, increased awareness and information, options for arrangements that support self-determination, and a well-compensated workforce.

4.1 D. Person-Centered Planning and Self-Determination

Person-Centered Planning is a method for identifying an individual's needs and desires and make meaningful choices regarding their lives, self-determination is the belief and value that individuals who need supports and services have freedom and authority to manage their individual budget and directly employ or contract with their service providers. All people who are receiving MI Choice waiver services have the right to develop their supports and services through the Person-Centered Planning process. By the end of 2007, individuals receiving services from any waiver agent in the state also will be able to choose to participate in the Michigan Self-Determination in Long-Term Care program, which enables individuals to choose and employ their own providers, including personal care workers, and to manage the individual budget authorized by the waiver agent.

4 IV. Implementation of Person-Centered Planning

4.1 A. PCP Values and Principles

Person-Centered Planning is an individualized process designed to respond to the expressed needs/desires of the individual.

- Each individual has strengths and the ability to express preferences and to make choices.

The individual's choices and preferences shall always be honored and considered if not always included in the plan due to health and welfare concerns or budgetary restraints.

- Each individual can contribute to the community, and has the ability to choose how supports and services may help them meaningfully participate in and contribute to the community.

- Person-Centered Planning processes maximize independence, create community connections, and work towards achieving the individual's

dreams, goals and desires.

- A person's cultural background shall be recognized and valued in the planning process.[1]

4.1 B. Essential Elements for Person-Centered Planning

There are a number of methods available to accomplish Person-Centered Planning, including, but not limited to: Individual Service Design, Personal Futures Planning, MAPS, Essential Lifestyle Planning, Planning Alternative Tomorrows With Hope. This Guideline does not endorse any particular method or model. Regardless of the model used or whether a formal model is used at all, the following characteristics of Person-Centered Planning are essential to the process of planning with an individual and his/her allies.

1. Person-Directed The plan for the individual is the individual's vision of what he or she would like to be or do. The plan is not static, but rather it changes as new opportunities and challenges arise.

2. Capacity Building Planning focuses on an individual's gifts, talents and skills rather than deficits. It builds upon the individual's ability to engage in activities that promote a sense of belonging in the community.

3. Person-Centered The focus is continually on the individual for whom the plan is being developed and not on fitting the person into available slots in a standard program. The individual's choices and preferences must be honored. If the individual does not communicate verbally, the process accommodates him or her to ensure that the individual's choices and preferences are honored. Guidance on Behavior as Communication is provided below.

4. Network Building The process brings people together both to support an individual (by involving allies in the planning process and honoring their role in individuals' lives) and to support the larger community (by involving community members and by providing a mechanism for individuals receiving services to connect with one another and with community members as desired).

5. Outcome-Based The plan focuses on increasing any or all of the following experiences, which are valued by the individual:

[1] Adapted from Person-Centered Planning Policy and Practice Guideline, Michigan Department of Community Health, October 2002.

- Growing in relationships or having friends
- Contributing or performing meaningful activities
- Sharing ordinary places or being part of their own community
- Gaining respect or having a valued role that expresses their gifts and talents
- Making choices that are meaningful and express individual identity
- Addressing health and welfare needs
- Planning for end-of-life support, when necessary.

6. Community Accountability The service plan will assure adequate supports when there are issues of health and welfare, while respecting each individual and according him or her dignity as a participating member of the community.[2]

7. Presumed Competence Person-Centered Planning is based on the premise that everyone has preferences that can form the foundation for how they want to live their life and what their dreams, goals and desires are. The focus is on these preferences instead of on an individual's disabilities, deficits, or level of capacity. In fact, all individuals are presumed to have the capacity to actively participate in the planning process. As described below, it is incumbent on the supports coordinator and the individual's allies to find a method to communicate with the individual and discern his or her preferences.

8. Information and Guidance When an individual is planning for arrangements that support self-determination, the Person-Centered Planning process must address the individual's need for information, guidance and support. Information and guidance may relate to the Person-Centered Planning process, options for supports and services, or it may directly relate to a particular need of the individual (such as what living situation would best meet the individual's needs and desires, what activities does the individual wish to pursue, strategies to build or rebuild and maintain relationships, the implications and consequences of a particular choice, or ways to become involved in the individual's community). Information and guidance is essential during the planning process, but also may be needed as service and supports are implemented.

Options should be drawn as broadly as possible from the ranges of long-term care services and generic community supports. Individuals must learn about options in ways that are useful to them. For some individuals, it may be sufficient to provide a written description of services at the beginning of the Person-Centered Planning process or when seeking information about an option. Other individuals may need to learn about options through explanation, observation or experience. The individual

[2] Items #1-6 were adapted from resolution adopted by the Howell Group of Michigan, October 1994

may need to try an option before making a decision. The timing for the learning and decision-making processes might need to be closely aligned.

9. Participation of Allies For most people, the Person-Centered Planning relies on the participation of allies chosen by the individual because of their commitment to support him or her. Most people living in their community already have the involvement of family members, friends, peers; an individual may choose these people as their allies. Individuals may also have important relationships with paid personal assistance workers or other professionals. Each individual's situation and relationships are unique. Some people will want to seek out allies; others will choose to use the Person-Centered Planning process without them. The individual determines who is an ally and may exclude family members or friends for various reasons.

The participation of allies is important for broadening the planning input and sources of support. Allies can help individuals explore their options, articulate their vision of a desirable future, make choices for the future and find ways to solve problems. Chosen allies can be very helpful to the individual and to the supports coordinator in assisting and supporting the individual on a continuing basis as needs arise. Together, the individual and his or her allies learn together and invent new courses of action to make the vision a reality. Individuals who cannot identify family members or friends to participate should be offered support for cultivating allies who can provide this very critical assistance.

10. Documentation The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan. The individual should be aware of and approve all distribution of planning documentation.

V. Practical Considerations in Person-Centered Planning

A. Planning for Health & Welfare

The service plan and Person-Centered Planning process must balance health and welfare issues with the individual's right to make his or her own choices. Specific issues of health and welfare must be examined and addressed so that an individual will not find himself or herself in a situation where he or she is at imminent risk. The supports coordinator is responsible for ensuring that issues of health, safety and welfare specific to the individual are brought up, discussed and resolved through the Person-Centered Planning process. Solutions must assure the health and welfare of the individual in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction.

Typically, an important need is for a workable back-up system to provide support in the event that providers are unable to be present for a work shift or duty. There a variety of ways to structure a back-up plan and an individual, with his or her supports coordinator and allies, can develop a back-up plan that meets the needs of the individual.

An individual may choose to address a sensitive health and welfare issue privately with the supports coordinator, rather than within a group planning process. Regardless of how it is done, the supports coordinator has an obligation to ensure that all health and welfare issues are addressed. When the individual makes a decision contrary to the support coordinator's or another professional's recommendation, the supports coordinator must ensure that the individual has information about all available options, document the individual choice, and revisit the issue as needed.

Sometimes, an individual's choices about how their supports and services are provided cannot be supported by the MI Choice waiver program, because the choices pose an imminent risk to the health and welfare of the individual or others. However, these decisions are made as part of the planning process in which the individual and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the individual's needs and satisfy their dreams and goals.

4.1 B. Person-Centered Planning and Aging

The Person-Centered Planning process was originally developed and implemented with people with developmental disabilities. Often these were young people who were planning their whole life: the type of work or meaningful activities in which they would participate, where they would live, how they would develop friends and relationships.

Unlike younger people, older individuals have a whole lifetime of choices behind them. They have established a residence, chosen a career or life activities, found hobbies or other meaningful activities, developed friendships and relationships. Even when a person is unable to communicate because he or she has developed an incapacity, this lifetime of choices can be used to discern preferences and priorities. When a person is unable to communicate, life choices can be identified from the individual's surroundings (the presence or absence of photos; or the display of artwork, crafts, collections or awards).

Often, planning with older people focuses on how they can maintain or accommodate their current life. For example, an individual may need personal care or environmental modifications to be able to stay in his or her lifelong home. A person who no longer has

the strength or energy to pursue their lifelong hobbies may choose to explore new pastimes.

When a person is in the later stages of life, the challenge may not only be preserving and extending the sources of joy. The individual may need support with a source of frustration or sadness—for example, grieving a deceased spouse or healing a broken or strained relationship with a family member or friend.

For individuals who are dealing with end of life issues, the planning process may involve where an individual wants to die, who they want to be with them, or who they don't want to be with them when they die. Other issues to consider could be; what kind of life-sustaining treatment they want or do not want, and what measures they need to make them as comfortable as possible. The planning process may include a variety of ways to help an individual come to terms with the dying process and obtain needed closure.

4.1 C. Behavior as Communication

Supports Coordinators ensure that the individual has the chance to ask questions and the options and choices clearly explained and thoroughly discussed. If the individual needs help understanding something or communicating thoughts, the individual, with his or her allies and/or supports coordinator must determine the best way to facilitate the individual's participation in the discussion.

People with disabilities communicate in a variety of ways. Some people use technology, others use hand signals, some use their voice, and others use picture systems. Some people can only signal yes or no using movement of their head, a hand, or another part of their body.

All people communicate through their behavior; for individuals who do not have other means of communication, behavior may be the primary means of communication. For many people who use behavior to communicate, their behavior may be seen as negative (they may yell, throw an item they do not want, throw a tantrum, or become aggressive).

Supports Coordinators and allies must learn to interpret an individual's behavior to determine what he or she may be communicating. Some behavior communicates emotions such as fear, discomfort, anger, or dislike. Other behavior communicates that the individual has a certain need or request or may want a certain solution or result. The behavior is unique to the individual. Efforts must be made to understand the communication and to find positive methods for the individual to communicate.

4.1 D. Involvement of a Designated Representative

Sometimes, a person may wish to choose to designate an ally to help him or her in the planning process. An individual who does not have a guardian may designate another person to help him or her with the Person-Centered Planning process and in implementing the supports and services chosen in that process. Selecting a personal representative may be done formally, by executing a power of attorney, or informally, by asking the representative to serve. Through the Person-Centered Planning process, the individual and his or her allies may determine the best person or persons to serve as representative. A representative must be able and willing to honor the choices and preferences of the individual and support him or her to take as active role in the process as possible. In the event a personal representative is working counter to the individual's interests, the supports coordinator is authorized to address the issue and work with the individual to find an appropriate resolution.

E. Individual Monitoring and Evaluation of Progress and Outcomes

Just as the individual chooses his or her goals and the supports and services needed to achieve them, the individual should also evaluate progress toward those goals and the outcomes of the service plan. The supports coordinator can support the individual in this evaluation process (evaluation questions and surveys include standard ones required by the waiver agent or individual ones developed by the individual during the Person-Centered Planning process); they can be simple or lengthy. Evaluation may lead to reconvening the Person-Centered Planning process to modify the service plan or resolve a challenge that has arisen.

4.1 F. Independent Facilitation

An Independent Facilitator is a person chosen by the individual to guide him or her through the Person-Centered Planning process. An independent facilitator may be a family member or friend or may be an advocate recommended by a friend, provider or supports coordinator. Whether an independent facilitator is used and whom the individual chooses for independent facilitation is up to the individual.

The individual may use an independent facilitator if he or she wants or needs to have someone that assists the individual and advocates for the individual's dreams and goals. Some individuals find it helpful to have a person involved who is outside of the waiver agent and does not make decisions to authorize supports and services and funding. Other individuals like having assistance in arranging the details of the meeting or leading the meeting. An independent facilitator can do one or all of these tasks.

The independent facilitator helps the individual with the pre-planning activities for the Person-Centered Planning process. These activities include who will be involved, the topics to be discussed, and the individual's goals and objectives. When the individual chooses to involve an independent facilitator, the supports coordinator may not be involved in the pre-planning process. The facilitator serves as the individual's advocate throughout the process, making sure that his or her needs and concerns are heard and addressed.

7 VI. The Steps of Person-Centered Planning

A successful Person-Centered Planning process puts individuals in charge of their own lives and planning, focuses on strengths, skills and/or life accomplishments, and acknowledges and honors individual preferences. A supports coordinator supports, guides, informs and assists the individual in learning about the Person-Centered Planning process and assures that the individual controls the Person-Centered Planning process. The planning process is not a single meeting. The individual may have a meeting every year, or more often, if needed. The individual may call a Person-Centered Planning meeting every time his or her wants and needs change.

4.1 Step #1 – Initial Contact & Getting Started

The Person-Centered process begins as soon as the individual enters the long-term care system and continues as the individual seeks changes. A supports coordinator chosen by the individual helps him or her navigate through the full array of services, supports, settings, and options. The supports coordinator ensures that the individual is provided with information regarding choices the individual can make. The supports coordinator provides information on the option for independent facilitation. Even if the individual chooses an independent facilitator, the supports coordinator is involved in the Person-Centered Planning process and authorization of supports and services paid for by the waiver agent.

Often individuals enter the long-term care system in a medical or other crisis. In those situations, immediate steps are taken to resolve the crisis and stabilize the individual's situation. Person-centered planning can begin only after the crisis is resolved.

4.1 Step #2 – Pre-Planning

Individuals must have opportunities to prepare for Person-Centered Planning process. This includes understanding the purpose, key aspects of the process (e.g. roles of the meeting participants, discussion questions for the meetings), and the options under consideration. The individual can choose to do a pre-plan with his or her supports coordinator, an independent facilitator or a trusted ally or allies. Preparation should occur in ways that are effective for the individual, which may include a planning

meeting or meetings, role-playing or practice sessions, written information or other methods.

- **Scope of the planning** The individual determines the scope of the planning. Person-Centered Planning generally asks the person to think broadly about dreams, goals and priorities. However, an individual can choose to talk about a specific topic, or challenge or even what is working or not working in his or her daily life. Both can improve an individual's quality of life and ability to maintain a life in the community.

- **Relationship between Person-Centered Planning and service plan** One implication of the broad scope of Person-Centered Planning is that it informs service or care planning; that is, the individual's life plans should give direction to supports and services that the individual needs in order to realize his or her goals. The Person-Centered Planning process is also the way the individual determines the type of supports and services he or she needs that are authorized and paid for by the waiver and who will provide the services and supports. This plan is called a service plan**.** The purpose of the plan is to help the individual to be as independent and self-sufficient as possible and build ways for them to participate in their community as desired. These supports and services include Medicaid covered services, waiver services, and services available from other government programs. The service plan must contain the date the service is to begin, the specified scope, duration, intensity of each service and who provides the service. The individual's plan may also include informal supports that family and friends provide, as well as supports and services from other government programs.

- **Individual control over the planning process as well** The individual's choices include choosing the meeting participants, participant roles (e.g. who will facilitate), location, schedule, and meeting agenda. The site and time of the meetings should accommodate the individual and key allies. The agenda should include issues the individual wants to discuss; it should also exclude issues the individual does not want to discuss.

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4.1 Topics for pre-planning

In pre-planning, the individual should think about and choose:

- the dreams, goals, desires and the topics the individual wants to talk about at the meeting
- likes and dislikes, what the individual would like more or less of in his or her life, and what the individual seeks to change
- fears or concerns the person identifies as topics for discussion.

- topics the individual does not want talked about at the meeting
- who, among their friends, family members, professional providers, staff, and fellow community members the individual wants to invite to participate in the Person-Centered Planning process
- where and when the meeting will be held
- who leads the meeting and the discussion. The individual may want to lead the discussion. The individual may want their supports coordinator to facilitate the meeting or they may want to select an independent facilitator to lead the discussion
- who records in writing what happens at the meeting

4.1 Topics for a Person-Centered Planning meeting

These will vary, depending on the individual, but could include:

- What are the individual's goals and dreams for the future or how do they want to live his or her life?
- What does the individual want more or less of in his or her life?
- Who does the individual want to spend time with?
- What new things would the individual like to do or learn?
- What are some great things others should know about the individual?
- What help and assistance does the individual need?
- What things could get in the way of the individual's dreams and goals?
- What does the individual like to do in his or her free time?
- What supports and services does the individual need to achieve his or her goals and dreams?
- What activities is the individual interested in? (job, hobbies, recreational activities, or volunteer opportunities)
- What health and welfare needs does the individual have?

4.1 Step #3 – The Person-Centered Planning Process

The planning process is not a single meeting. The individual may have a meeting every year, or more often, if needed. The individual may call a Person-Centered Planning meeting every time his or her wants and needs change.

A Person-Centered Planning meeting may begin with all of the participants introducing themselves and sharing why they are participating in the meeting.
The meeting may start with what is currently working and not working for the individual. Or the individual may start by sharing his or her hopes, dreams and desires for the future. Everyone gets to know the individual better and helps the individual with developing his or her plan to the extent help is asked for by the individual. The individual talks about what may get in the way of achieving his or her goals. It may be a physical or health issue or a skill that the individual wants or needs to learn, or a type

of assistance or support that the individual needs. Health and welfare issues are also discussed.

After all of the issues are discussed, the individual and their allies work together to determine what supports and services the individual needs to achieve their goals and dreams and who can help the individual do so. These include the paid supports in the individual's service plan, and the unpaid supports such as the help the individual's friends, family members and other allies provide the individual. The plan may be completed in a single meeting or it may evolve over several sessions.

If the individual is unhappy with his or her service plan, the individual must let their supports coordinator know. The individual has the right to reconvene the Person-Centered Planning process or to appeal through the Michigan Department of Community Health Fair Hearing Process. The waiver agent also has a dispute resolutions process.

VII. Organizational Components for Implementing 9 Person-Centered Planning

Shifting from traditional service delivery methods to developing and implementing service plans through the Person-Centered Planning process requires a change in the organization's orientation. Instead of fitting individuals into existing programs, available supports and services must be adapted to meet the needs and desires of the individuals. The following characteristics are essential for organizations responsible for providing supports and services through the Person-Centered Planning process.

4.1 A. Person First Language

Person first language puts the person before the medical, physical or mental condition and maintains the emphasis on the humanity and dignity of the individual. For example, instead of *arthritic person*, the appropriate term would *person with arthritis*. Using person first language is an important first step in reorienting the organization toward the individuals and their needs and desires. Instead of viewing individuals through the narrow scope of their condition or disability, the needs of the whole individual, as well as his or her support system, are identified and addressed.

4.1 B. Person-Centered Orientation

The focus must continually be on the individual for whom the plan is being developed and not on plugging that person into available slots in programs. Waiver agents have the responsibility to avoid unintended and detrimental consequences of their involvement, such as individuals becoming disempowered by deferring to professional

decision-making, or families becoming displaced by service providers. The general strategy for avoiding these consequences is to presume competence and capacity by the individual, allies and the community, and to only provide assistance when the current situation leaves unmet needs. Just as the language for individuals receiving services has changed, the term supports coordinator has replaced terms such as care manager or case manager to identify the change in role from one who is managing or directing care to one who is supporting an individual to self direct their supports and services.

4.1 C. Training, Mentoring and Support for Staff

The staff should have training and supervision to ensure that they have the knowledge and capacity to meet their PCP responsibilities. These responsibilities may include: providing information and guidance to individuals receiving or seeking supports and services, facilitating the planning meetings as requested by the individual, suggesting creative strategies to address the needs and desires of the individual, and monitoring the effectiveness of the Person-Centered Planning process and service implementation. Training in the tools and methods of Person-Centered Planning process is critical in giving supports coordinators the background to support a variety of individuals and provide a unique response to each individual; peer mentoring and support may be helpful to develop support coordinator capacity in this area. In addition, support coordinator positions should be designed to accommodate this new role. For example, caseload size must allow for sufficient personal contact, authority to make decisions in support of the individuals' choices, flexible hours and minimal competing duties. Staff performance reviews should include consideration of how well the staff person contributes to Person-Centered Planning, supports individual choice and helps realize individual goals. Staff performance evaluation should include Person-Centered Planning performance.

4.1 D. Community Resource Development

Information on community resources must be available to all staff and individuals. Waiver agents must map community resources and options for community involvement and participation in which individuals express interest must be investigated. The waiver agent must work with other community and government organizations to resolve barriers and advance common aims. This collaborative may include developing resources to meet unmet needs and developing collaborative agreements to resolve barriers and ensure effective resource utilization.

4.1 E. Information and Guidance

Each waiver agent must have an organizational commitment to provide information and/or experiences that sufficiently inform an individual of her or his options. Upon initial screening and eligibility determination, supports coordinators must provide individuals and their allies with written information about the right to the Person-

Centered Planning process. Supports coordinators may also ensure that individuals have tools to successfully use the Person-Centered Planning process, develop individual quality service expectations that address preferences and evaluation of personal outcomes and goals, and implement arrangements that meet their needs. The supports coordinator must offer additional information and support to the individual and directly address concerns that the individual may have either over the phone or in a face-to-face meeting. Continued assistance is available throughout the planning process, which continues and evolves as each individual receives waiver services. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g. Braille, sign language, audio-recorded documents), hands-on experiences with options and peer support from individuals who have experience using the same supports and services. Individuals and their allies are provided with telephone numbers to contact supports coordinators when new needs emerge that require the assistance of the supports coordinator or the reconvening of the Person-Centered Planning process.

F. Evaluation and Quality Management

4.1 *The effectiveness of both the person-centered planning process and the outcomes of that process must be evaluated. The approach to evaluation and quality management must collect and use data, including feedback from individuals on their views of the success of the Person-Centered Planning process and how the process impacts both the service plan development and service plan utilization. Data must be sought through multiple methods such as mail, phone or in-person surveys, focus groups, and other feedback loops.*

4.1 *Measures on the effectiveness and success of the person-centered planning process include whether: the individual invites allies important to them to participate in the process, the individual decides who will run person-centered planning meetings, the individual chooses meeting topics and the time and location of the meeting, and the individual's wants and needs are included in the service plan. A short written survey to evaluate the planning process must be provided to the participant with the authorized service plan; follow-up must be offered to assist the individual in completing the survey in the way that works best for him or her within 30 days of completion of the planning process.*

4.1 *Evaluation of the outcomes of the person-centered planning process include how the services and supports in the plan impact on the individual's ability to realize personal choices, maintain or increase individual's quality of life, and assist in achieving his or her dreams and goals. Data should also be collected and analyzed to assess the impact of the Person-Centered Planning process on individual choices—both realized and not realized, barriers to realizing choices and achieving goals, and efforts to resolve barriers and assess participant quality of*

life. This data should be collected and analyzed using the Participant Outcome Status Measures (POSM) Quality of Life Assessment at least annually.

This quality management process and resulting data is used to improve services and make decisions that lead to better lives for individuals. The goal is to develop a sense of the success of PCP from the individual's viewpoint. Individual preferences are identified in through the Person-Centered Planning process and the evaluation and quality management process needs to reflect the success of supports and services to both include and address these preferences. This management information should be considered in organizational planning, including allocating resources.

After person-centered planning has been implemented over a period of time, the service plans and individual budgets when reviewed across the system can provide useful information about what supports and services are being used by individuals and how resources are being allocated. Such an evaluation is valuable source for information on individual preferences that can provide guidance on how financial and other resources may be allocated in the future and what community capacity and relationships need to be developed.

10 VIII. Glossary

Allies Friends, family members and others that the individual chooses to assist him or her in the Person-Centered Planning process. Allies participate because of their commitment to supporting the individual, not because participation is one of their job duties. The individual determines who is an ally. Allies *may* include family members, friends, or advocates. Allies are not paid professionals (even though professionals may be very committed to supporting the individual).

Arrangements that support self-determination Methods for an individual to accomplish self-determination in his or her life.

Independent Facilitator A person the individual chooses to guide and support him or her through the Person-Centered Planning process.

Independent Living The term used for both the philosophy and the movement that all people with disabilities, including people with significant disabilities, can maintain a life in the community—with work or other activities, a home, and personal relationships—if they have the right supports and services.

Service Plan The plan of supports and services for an individual that will be authorized and paid by the waiver agent.

Medicaid A government program that provides funding for supports and services authorized by the waiver agent.

Person-Centered Planning Process a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices and abilities.

Self-Determination The belief and value that individuals who need supports and services have the freedom to define their lives, make meaningful choices regarding their lives and have the opportunity to direct the supports and services they need to pursue their lives.

Waiver Agent The agency that authorizes the individual's service plan.

Supports Coordinator A person who works for the waiver agent and works with an individual to develop and authorize a service plan. The supports coordinator also provides other assistance and support to the individuals they serve.